Hospital Progress

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OAK PARK HOSPITAL, OAK PARK, ILL. Richard E. Schmidt, Garden & Martin, Architects, Chicago, Ill.

Planning for the Future

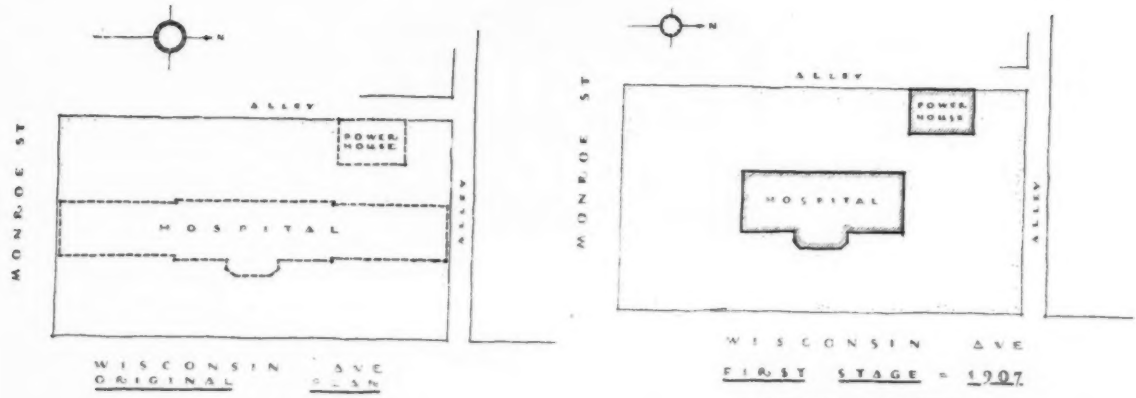
A Study of the Development of the Oak Park Hospital

By Mother St. Beatrice, Superior of the Sisters of Misericorde, and Carl A. Erickson of Richard E. Schmidt, Garden & Martin, Architects

In 1905 Oak Park was a simple village of home owners—self-satisfied, smug, and complacent home owners—most of them commuting to Chicago for business and recreation, very predominantly Protestant and American in descent with a sprinkling of well-to-do and an overwhelming percentage of the middle class.

Only one and one-half miles wide and two and one-half miles long, its southern fringe promised to develop into a workers' settlement, while at its southwestern boundary was the thrifty German settlement known as Forest Park. On the northwest the village of River Forest had only begun to develop. There were practically no factories within its boundaries; a typical satellite village of an "uppish" caste, an "aristocratic suburb."

Its arteries of communication and supply with Chicago were the "Northwestern" suburban service which passed through the middle of the village easterly and westerly, and a rheumatic street car system tapping the city at four points. These and the one good highway to town passed a number of miles of desolate prairies before reaching the city (the east boundary is seven and one-half miles from the center of Chicago).

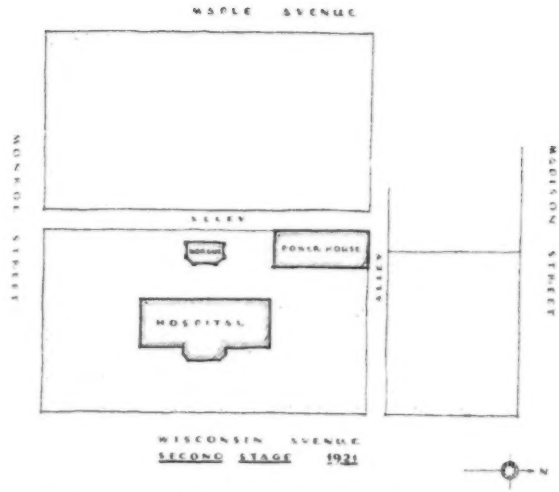


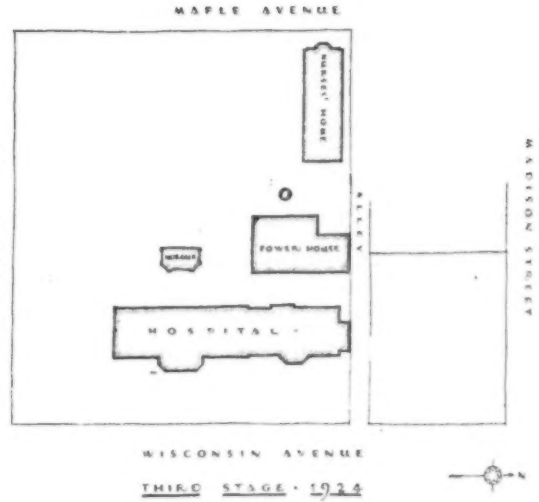
The physicians were dependent for hospital care on that group of hospitals surrounding Cook County Hospital, about five or six miles away. Serious illness was usually cared for in the home, for while complaint was even then being made of the quality and quantity of domestic help, it could be had. A private nurse was an extraordinary luxury.

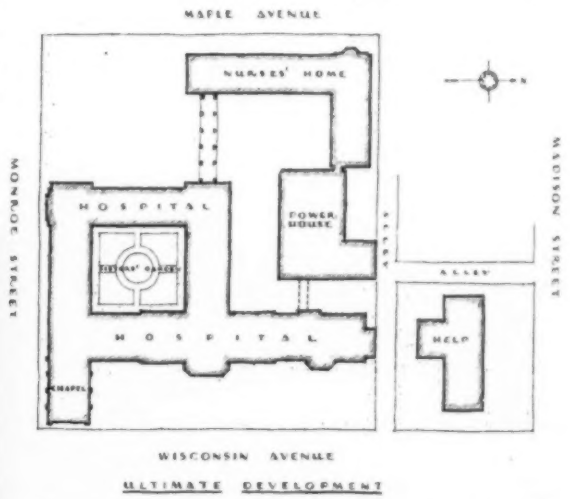
The Vision of Pioneers

Dr. J. W. Tope, the leading physician of the village, recognized the handicaps from which the village suffered, and it is largely through his efforts that the Sisters of Misericorde were invited to start a hospital here. An apparently ample site was purchased by some of the doctors and the prominent citizens, and donated to the Sisters.

MAP SHOWING ELEVATION OF HOSPITAL WITH REFERENCE TO OTHER HOSPITALS AND TO ITS "ENVIRONS." OAK PARK HOSPITAL, OAK PARK, ILL.
Richard E. Schmidt, Garden & Martin, Architects, Chicago, Ill.

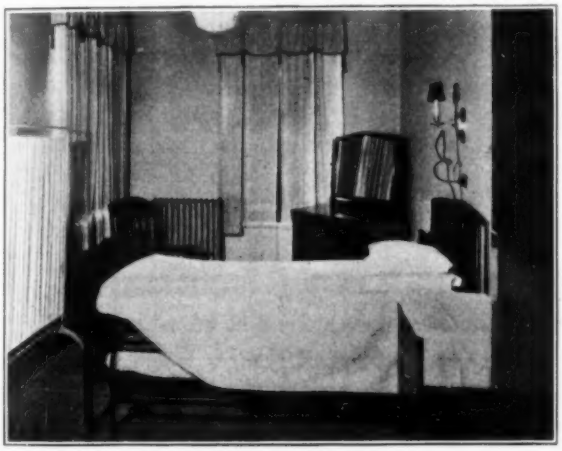






The central building, a five-story fireproof structure, was completed and occupied in 1907. The first superior, Mother St. Laurence, quite evidently had a vision of the possibilities of growth and of service. She builded well and with an eye to the future.

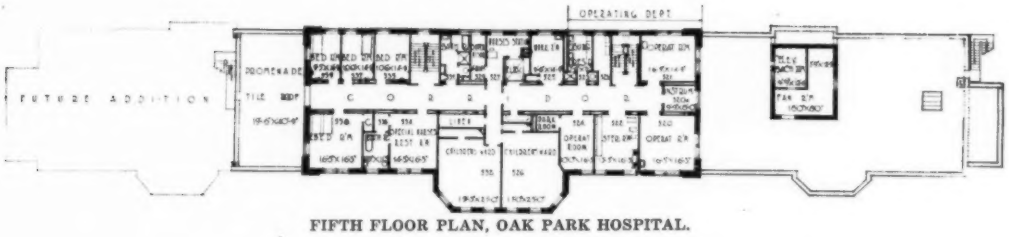
It was rather startling to find that she had not only planned the initial building with great care, but had sketches prepared for extension at either end. That initial building is an excellent example of a wise and far-sighted building policy. It would have been so much easier for the Sisters pioneering in a distinctly Protestant community, to have hesitated at the large initial expenditure necessary to build as they did.



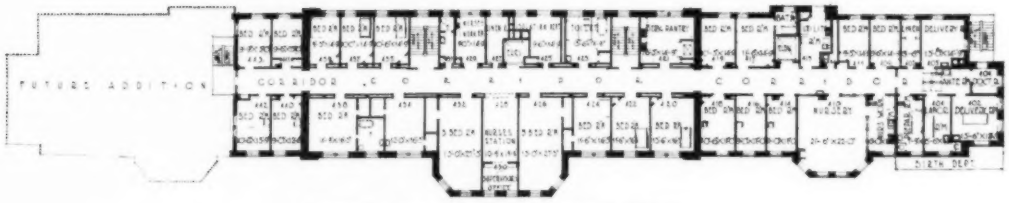
PRIVATE ROOM.

NURSES' CLASS ROOM.

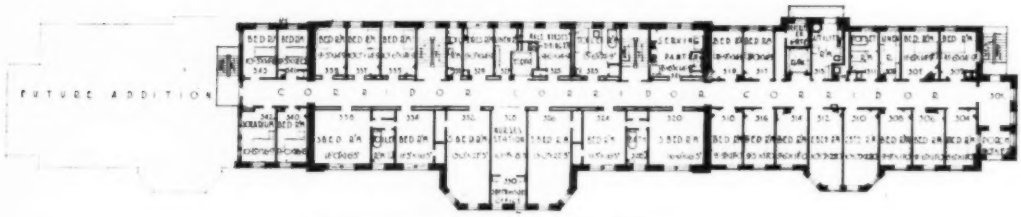
NURSES' DINING ROOM.



FIFTH FLOOR PLAN, OAK PARK HOSPITAL.

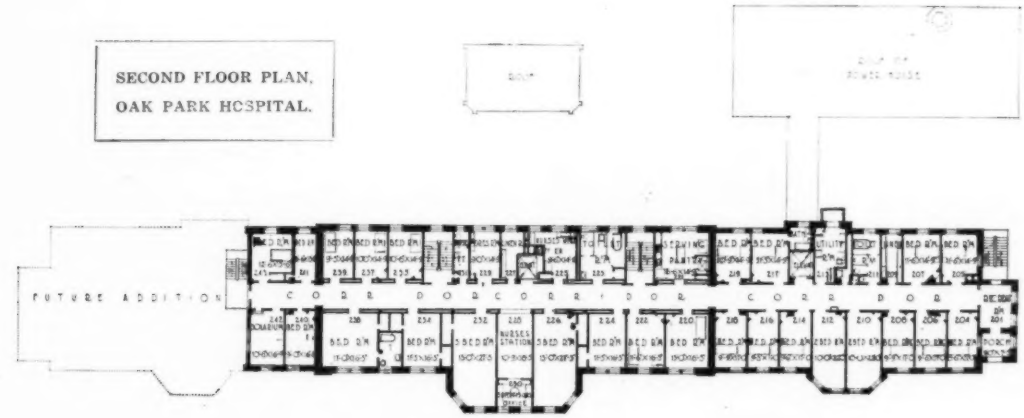


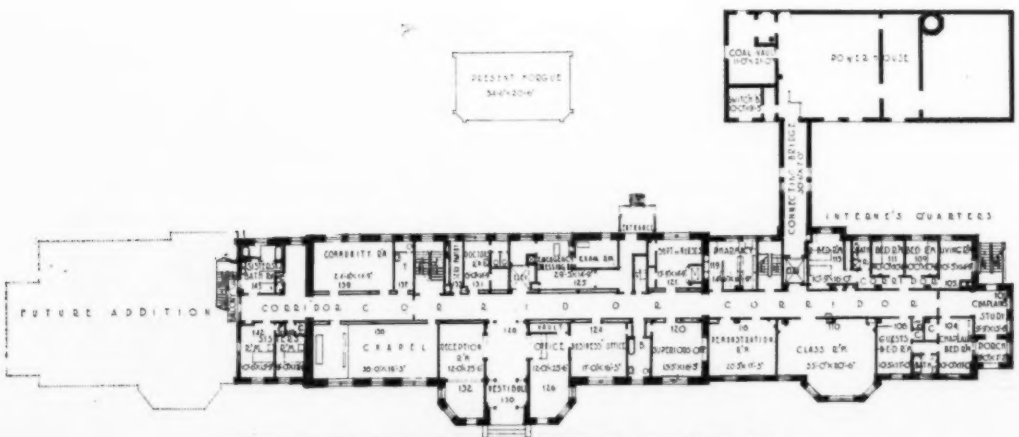
FOURTH FLOOR PLAN, OAK PARK HOSPITAL.



THIRD FLOOR PLAN, OAK PARK HOSPITAL.

SECOND FLOOR PLAN,
OAK PARK HOSPITAL.





FIRST FLOOR PLAN, OAK PARK HOSPITAL, OAK PARK, ILL.
Richard E. Schmidt, Garden & Martin, Architects, Chicago, Ill.

Time has justified their faith manifold. Their good work has resulted in very marked economies of maintenance and operation. Today, after seventeen years of continuous operation, the hospital has every appearance of a recent building, and seventeen years is an acid test. The hardships endured by the Sisters during the first years cannot be detailed here. Gradually, however, the hospital filled up, forcing the Sisters and nurses out of the building into adjacent houses, first rented and later purchased. That the vision of the first superior was never lost sight of either at the hospital or at the motherhouse is evident, for by 1922 the hospital had acquired almost the entire block upon which it stood.

A Growing and Changing Community

But the community it served grew faster than the hospital, and in 1912 a proprietary hospital was opened at the eastern limits of the village. In spite of this the demand for beds grew until there was a constant waiting list. For various reasons building was postponed until 1923.

In the meantime the population of the village had increased from 15,000 to 50,000; the tributary population through the common use of the automobile and better roads, to about 100,000.

But of even greater moment to the hospital has been the change in the character of the housing and in the availability of domestic help. From a community of home owners it has changed rapidly to one of apartment dwellers, and the greater majority of the apartments are from one to four rooms. Domestic help is not available except at high figures.

Sickness to the apartment dweller means only one thing—the hospital, for there is no room for the necessary nurses or the concomitant maid. It is obvious that where nurses and help (if they can be had) must be employed, it is far more economical and comfortable to use the hospital than the home. And childbirth in a two-room flat presents almost insurmountable difficulties.

Meeting New Needs

These factors, coupled with increasing appreciation of the value of hospital care both in childbirth and in illness, tend to throw on the hospitals a burden even heavier than was usual when the Oak Park Hospital was first opened in 1907, with what appeared to be an extravagantly large number of beds—100. The community now has at its disposal about 350 beds, a growth only proportionate to the increase in population, it is true, but one must not overlook the fact that the automobile has made the city hospitals more accessible.

In 1922 the immediate needs were quite obvious. Medically, the most important was the need for more and better obstetrical facilities and a larger x-ray department; economically, the demand for private rooms (the initial building provided few of these); and the need for better and larger kitchens, dining rooms, interns' quarters, nurses' teaching rooms, and a chapel.

An extension to the north lot line, with a small extension at the south end, was completed in the early part of 1924.

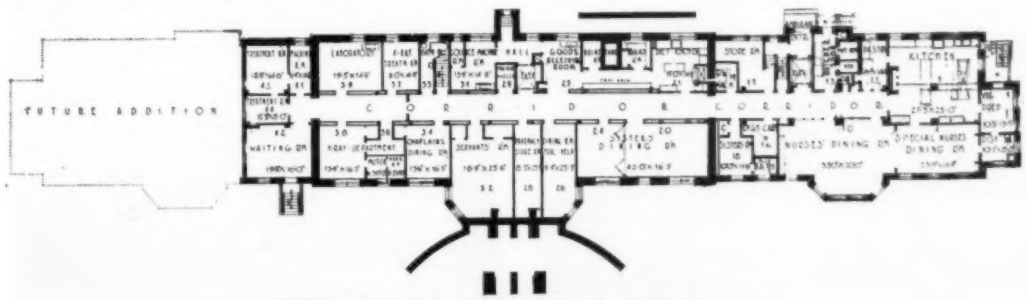
The entire basement was revamped (see illustration of nurses' dining room), the x-ray department considerably enlarged at the south end, and the new kitchen and dining room placed at the new north end. By careful study it was found possible to utilize the intervening section of the old building without many changes.

Ambulance and Laundry Facilities

Probably the only serious inconvenience of the otherwise well planned original building, was the entrance for ambulance and stretcher cases, which came into the hospital either through the front door or the rear, but in both cases only by way of a long flight of stairs. Another problem was that of the laundry collection and distribution. As originally planned, after the laundry on the floors had been collected in bags, the bags were transported down the elevator to the basement, from which they were carried up the stairs to grade, across the open, and up a steep flight of stairs to the laundry floor about ten feet above grade. The distribution was quite as laborious.

The provision of an additional bed capacity would have aggravated these problems considerably. It was recognized at once that an additional elevator was a necessity, if only as a reserve in case anything happened to the one originally installed.

Grouping elevators together is usually a sound principle, but hardly applicable here. In general it was agreed that the existing elevator should primarily be for passengers and the new one a service elevator. Its location was dictated by a desire to make it serve the laundry, which was a few steps below the second floor of the hospital.



BASEMENT PLAN, OAK PARK HOSPITAL, OAK PARK, ILL.
Richard E. Schmidt, Garden & Martin, Architects, Chicago, Ill.

UTILITY ROOM.

DELIVERY ROOM.

By providing the elevator with openings at the back, at levels half-way between the basement and first, and between first and second, it was found possible to build a bridge that would connect this elevator to the laundry floor less than fifty feet away and provide a covered ambulance entrance at grade. The clothes chute was so placed that it too may be emptied from the bridge, or passage to the laundry.

Something of the Plans

The north end of the first floor provides for a suite of three rooms and bath for that delightful and venerable man, Father Marcille, the chaplain. Across the corridor are the interns with two double rooms, a living room, and bath, all well segregated from the rest of the house. Just south of Father Marcille's quarters are two large rooms for the instruction of nurses, one a classroom, the other a typical ward for demonstration purposes.

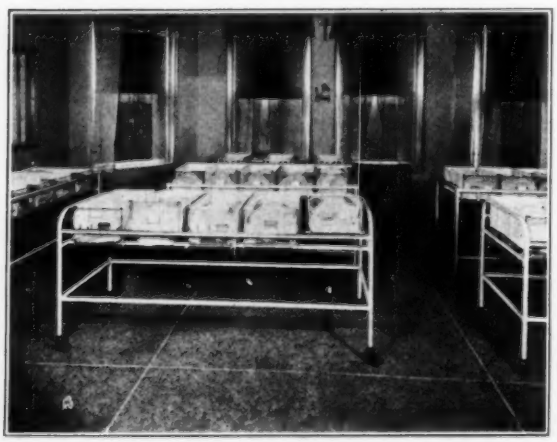
The pharmacy, which had outgrown its former quarters, was placed adjacent to the old building. These changes permitted the needed enlargement of the administrative offices (see plans). That portion of the building south of the entrance remained as originally planned, with the addition of two rooms and toilet facilities.

The plans of the second and third floors indicate the disposal of the new portions of the building, all devoted to private and a few semi-private rooms. The existing pantries, already too small, were eliminated and new ones provided in a former two-bed room. A new utility room replaces the old, inadequate space. Note the balcony opening off this room for airing clothes, etc., and the clothes chute opening directly from it. The third is the men's floor, with a room for the orderly—an unusual and valuable convenience.

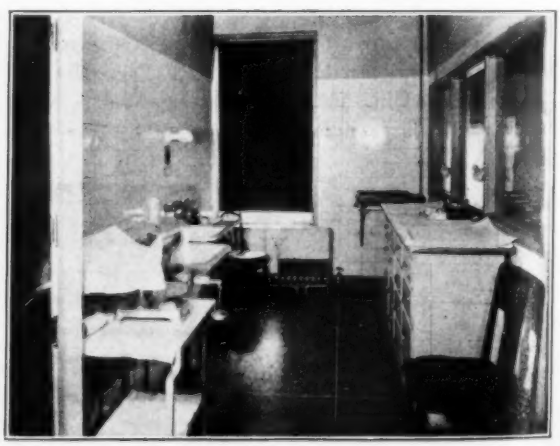
Other Modern Touches

The fourth floor probably will hold the interest longest, for this is the obstetrical floor. Two birth rooms, a waiting room, a labor room, and a preparation room comprise the birth department. At the end of the corridor is a rest room for physicians. The birth rooms are all tiled to the ceiling with mat-glazed green tile; the corridor is pearl gray; the floors are of gray flint tile.

Adjoining the birth department is the nursery, large, sunny, and airy with an adjoining work room in white tile. The walls between the nursery and the corridor are all glass, permitting friends to see the babies without actually touching them—and who can resist?



NURSERY.



NURSERY WORK ROOM.

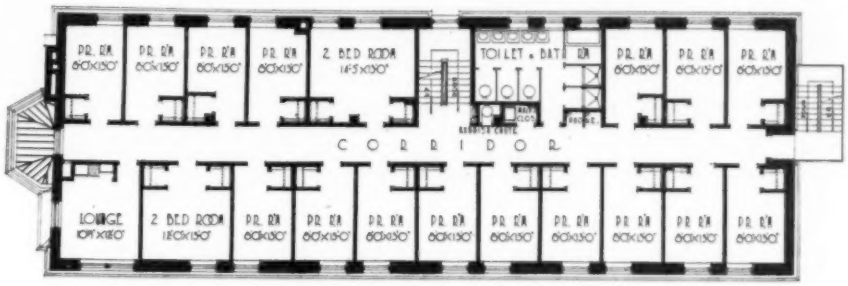
This is the place to take the grouches; for none can fail to enthuse over the little mites.

Those who read HOSPITAL PROGRESS scarcely need to be told that the new building is fireproof. They will not be surprised either if we add that the base is of terrazzo, coved, and that all internal angles are coved, or that it has a silent call system. They will be interested, however, in the fact that art marble (a form of terrazzo) floors were continued in the terrazzo in the new building. They will be especially interested to find that the wood floors used in the original building have been replaced by terrazzo in the new, to avoid the expensive maintenance of wood floors. The principle laid down by the founders—"build permanently"—has been observed throughout.

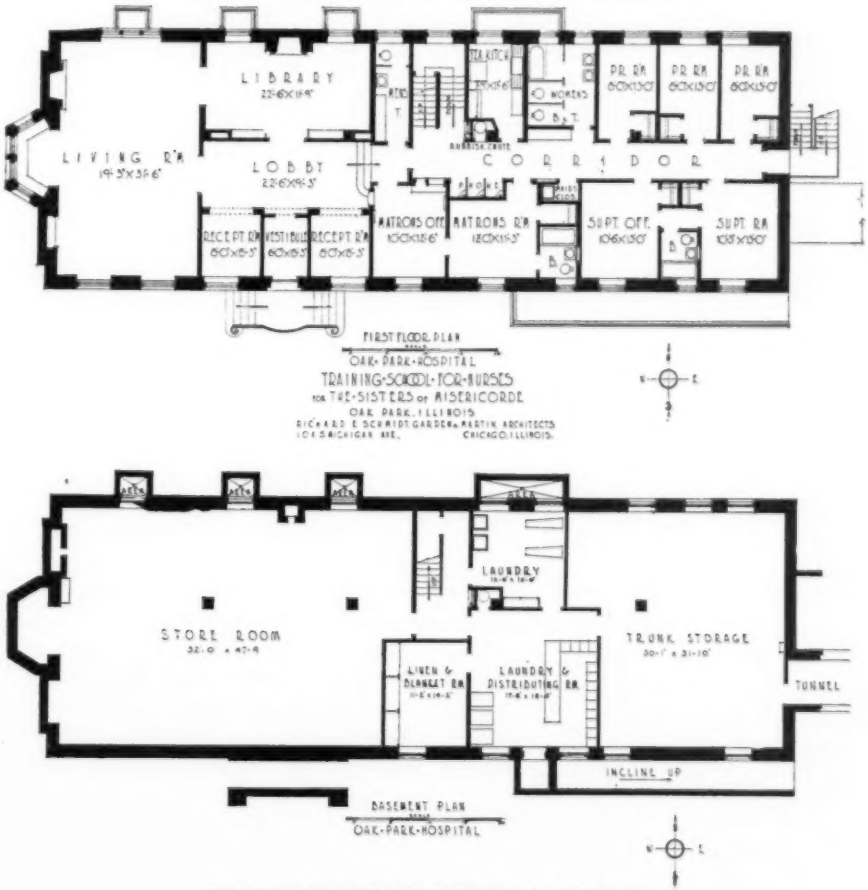
Accommodations for Nurses

From the inception of this building the serious situation in regard to housing nurses when the additions were completed, was already clearly recognized. It was almost impossible to find additional houses for this purpose, and such arrangements were regarded as generally unsatisfactory.

On the one hand, it was hoped that the new additions would immediately fill up in order that principal and interest on the indebtedness might be more readily met. On the other hand, it was hoped that it wouldn't



SECOND, THIRD AND FOURTH FLOOR PLAN OF THE OAK PARK TRAINING SCHOOL FOR NURSES, OAK PARK, ILL.
Richard E. Schmidt, Garden & Martin, Architects, Chicago, Ill.



TRAINING SCHOOL FOR NURSES, OAK PARK, ILL.
Richard E. Schmidt, Garden & Martin, Architects, Chicago, Ill.

SCHOOL FOR NURSES, OAK PARK HOSPITAL, OAK PARK, ILL.

fill up, so that the nurses might temporarily occupy some of the rooms in the hospital, to avoid the necessity of providing special quarters for them.

Even before the completion of the additions, the indications were quite clear that quarters for nurses must be provided, and the architects were instructed to proceed with drawings. It was recognized at once that the location of this new building required a careful analysis of the needs of the hospital and its relationship to community needs.

These have been briefly touched upon before but only as indicating why more hospital beds were needed at that time. What did the future hold forth?

The Sphere of the Hospital's Influence

The sphere of a hospital's influence is determined by transportation, the proximity of other hospitals, and its physicians.

Since the completion of the hospital additions early in 1924, automobile facilities to Chicago and to the neighboring villages have been further improved by the opening of new state roads and bus lines. And the number of automobiles is increasing far more rapidly than the population. The automobile and good highways readily extend the working radius of an urban hospital to fifteen or twenty miles. Those of you who operate in smaller cities will probably smile at this narrow determination of hospital sphere. Such a circle about the Oak Park Hospital would include several million people.

A limiting factor, however, is the presence of other hospitals. To the east was a hospital within one and one-half miles; to the southeast the nearest was St. Anthony's de Padua, about six miles away; to the south was a tiny one at Berwyn (lately announced plans for building); to the southwest one at Hinsdale, about twenty-five miles away; to the west none nearer than Aurora (30 miles); to the northwest none; and to the north none. It was obvious that the eastward radius of the hospital would necessarily be small because of the city hospitals; that its sphere of influence could not extend much beyond Oak Park proper, southward and westward, and to the northwest its influence would be limited only by its physicians and the construction of later hospitals.

A study of the population trend of the Chicago urban district showed that with the extension of rapid transit, bus lines, etc., a population of 500,000 could reasonably be expected in the next twenty-five years where there were then but 100,000.

RECEPTION ROOM.

Anticipating Developments

But a hospital without physicians is an idle gesture. At present, the staff is composed largely of physicians from the immediate vicinity, this because the available bed capacity is too small. That many more qualified physicians in the neighboring suburbs would gladly avail themselves of its facilities, were beds sufficient, is obvious. It is now necessary for them to use even farther removed hospitals for their cases, or treat them under the handicaps of home environment. The accident service of the hospital has repeatedly extended twenty miles westward.

While the hospital treats all alike, regardless of creed, yet it may be said to have a special obligation to those of its own faith. When the hospital was first opened it found few Catholics in the community. The near-by parish was not particularly populous nor wealthy. Since then there has been a marked increase in the proportion of Catholics in the community. A very notable girls' school has been erected (Rosary College) and a Dominican college is under construction. All of the parishes in the community have grown larger and more prosperous and some new ones have been formed.

It seems reasonable, then, to anticipate a growth to 500 beds within twenty-five years. The studies of the group development are based on such an assumption.

Guiding Principles

It was clearly recognized during the preparation of these studies that no one could foresee in detail the developments of the next twenty-five years. But an attempt was made. It was agreed that in addition to providing for the patients, space must be found for about 250 nurses, fifty to sixty Sisters, and seventy-five to one hundred helpers (it was assumed that some help would live outside). Here again the figures were put down as a guide only. Certain other principles were also set down for guidance:

(1) That the group plan as worked out must permit of development slowly or rapidly, in large bits or small, as the needs arise.

(2) That it must permit of the maximum of flexibility.

(3) That it should permit of "change with well considered notice."

(4) That it should not destroy what had been done before, but supplement it.

(5) That at all times the plant must be an efficient one.

The group plan (note illustration of original plan, developments, and ultimate plan) permits of all of these things. A closely knit, flexible, and efficient plan was sought and we believe secured. To insure good light and aid and economical operation, the future buildings (in the rear) will be nine stories high, whereas the present ones are but four and five stories. Provision has been made for expansions of the power house and laundry, the nurses' home, and all auxiliaries, in sufficient detail to provide that nothing done now shall interfere with the logical, orderly, and economical expansion of the hospital. Many are the hospitals which build, only to regret that they too did not work with an eye to the future.

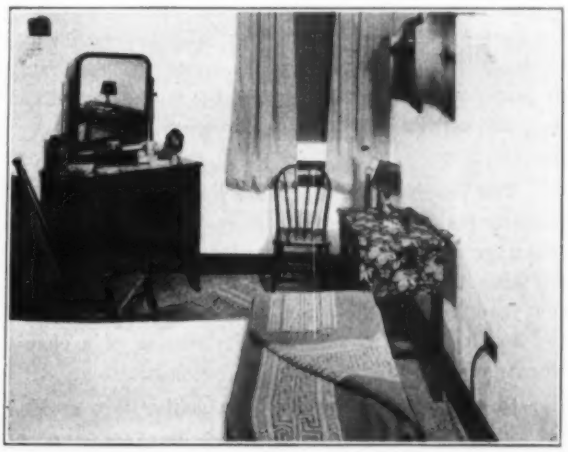
Results of the Study

With this study fifteen or twenty various arrangements were considered before one was arrived at which met all requirements. The location of the initial unit of the new nurses' home was a simple matter.

The by-products of this study of the group plan of the future were interesting. The inadequacy of a site chosen for the nurses' home some years earlier was demonstrated. A site selected for a chapel some time before was abandoned because the location would obviously interfere with the best interests and development of the hospital. A site was chosen which is far better in every way.

The New Nurses' Home

Contracts for the new nurses' home were let in April, 1924, and it was occupied in January, 1925, a four-story building housing sixty-two nurses and four Sisters. The entrance on the south front leads through a vestibule to a pleasant lobby upon which the matron's office opens. Two small alcoves off the foyer permit nurses to receive visitors without enduring the terrifying scrutiny of the entire school.



TYPICAL ROOM IN THE SCHOOL FOR NURSES.

NURSES' LIVING ROOM, SCHOOL FOR NURSES, OAK PARK HOSPITAL, OAK PARK, ILL.

Immediately in front of the lobby there is an attractive library, and to the left a large, well lighted, bay-window room with a large fireplace. On this floor, too, are a men's toilet, telephone booths, a tea kitchen, a coat and toilet room for nurses and a few rooms for their use, a suite for the superintendent of nurses, and a room and bath for the matron.

The matron's office is strategically located in oversight of the public rooms and at the entrance to the stairs.

The typical floors represent the latest thought in nurses' housing, small single rooms 8½x12 feet, including the closet. There are two double rooms on each floor, ample toilet and bathing facilities, and a "kimona lounge" where the girls may indulge in a fudge party or a card game in negligee. Each floor has its telephone and also a gong to get the girls up in the morning (controlled from the matron's office).

The basement contains a laundry for those things the nurses prefer to do themselves; a linen room for distribution and collection of linens, connected by a ramp to grade, to make it easier to get the laundry trucks in and out; a trunk room and a store room.

An Appeal for Foresight

The hospital is already too small and the nurses' home is just large enough for present needs, but both buildings may be readily expanded without destroying anything that has been done. Undoubtedly the next few years will see the completion of the south wing of the hospital, and with it the construction of a chapel worthy of this otherwise magnificent institution.

In this brief review we have deliberately avoided describing what will be obvious from an examination of the illustrations accompanying the article. If per chance we have left too much to the imagination of the reader, we beg indulgence.

Our aim has been rather to point out by actual illustration, the value of far-sighted planning for the future, and the genuine economy of building well. In far too many of our hospitals, and this is true of Sisters' hospitals as well as of the secular, a "penny wise and pound foolish" policy is pursued in building, with its unfailing retribution following as certainly as day does night.

If in addition it serves to strengthen the vision of those about to build, encourages them to peer into the future and intelligently to plan for it, we shall feel that this article is more than a frame for the illustrations.

PRIEST'S STUDY AT THE OAK PARK HOSPITAL, OAK PARK, ILL.

X-Ray Technique

The Second of a Series of Illustrated Articles by James F. Kelly, M.D., Omaha, Nebraska

IN LEARNING the significance of the terms antero-posterior and postero-anterior, otherwise known as A. P. and P. A., one will find them easy to remember if he thinks of the x-ray tube as representing his own eyes. By naming the proximal surface which one sees first, and then the distal anatomical surface which one sees last, one will name them right at all times (if one can recognize or identify the surface he sees first).

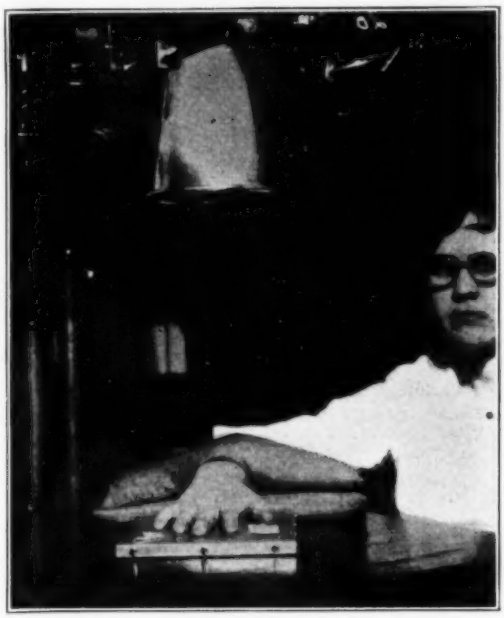


FIG. 3. POSTERO-ANTERIOR POSITION OF PHALANGES AND METACARPALS.

Thus in antero-posterior hand (Fig. 5).

If your eyes were in the position of the tube and you looked on the table at a hand in the antero-posterior view, you would see the palm first, i. e., the anterior surface of the hand, and (if you were able to see through the hand as the tube does) you would see the posterior surface last. Therefore the part is in the antero-posterior or A. P. view.

If the back of the hand were uppermost (Fig. 3) toward the tube, you would see the back or the posterior surface first, and the palm or anterior surface last. Therefore the part would be in the postero-anterior or P. A. position, etc.

FIG. 4. X-RAY PICTURE CORRESPONDING TO FIG. 3.
Metacarpals are numbered from 1 to 5. On the third and fourth metacarpals there is a "P" on the proximal or carpal end, and a "D" on the distal end or head.
The phalanges are lettered A., B. and C. A. for proximal or 1st; B. for second or middle, except on the thumb, where it is last; C. for distal, third, or last on fingers. The proximal phalanges of the third and fourth metacarpals are lettered with a "P" on the proximal end, and "D" on the distal end. Beyond their corresponding distal phalanges is written thumb, index finger, large finger, ring finger, small finger.

FIG. 5. ANTERO-POSTERIOR POSTURE FOR THE PHALANGES AND METACARPALS.

Following is the posture for all finger, hand, wrist, forearm, and elbow work if patient is ambulatory.

The patient should be seated comfortably near, either facing or alongside the table, and the part to be rayed should be resting easily and well supported, elevated or immobilized as required for the particular case.

Courtesy to the Patient

In any posture the desired position is the first essential; but next to that, comfort or ease follows closely. If an uncomfortable position cannot be avoided it should not be assumed any earlier than necessary nor maintained any longer than good technical results require. Always be kind and considerate of your patients. Some little thing of no consequence to you may be of great importance to them; always make them as comfortable as possible.

Although it is sometimes necessary to be firm to secure cooperation, it is never necessary to be any more

than that. Never be unnecessarily rough in manipulating an arm or a leg to place it as you wish. Be careful and considerate; you will get through just as soon.

A word of explanation as you go along will not only occupy the patient's mind and gain his favor, but will also make it possible for him to cooperate intelligently. What is simple to you may be, or very likely is,

FIG. 6. X-RAY PICTURE CORRESPONDING TO FIG. 5. LETTERS AND FIGURES THE SAME AS IN FIG. 4.

complicated to him. Tell the patient what you want him to do, and be careful.

X-ray Examination of the Fingers

The first metacarpal supports the two phalanges of the thumb. The fingers, for sake of identification, may be named as follows:

FIG. 7. BONY SKELETON OF THE HAND AND WRIST. LETTERS AND FIGURES THE SAME AS IN FIG. 4.

The finger of the second metacarpal (see Fig. 4) is the index or forefinger, the finger of the third metacarpal is the large or middle finger, the finger of the fourth metacarpal is the ring finger, and the finger of the fifth metacarpal is the small or little finger. The metacarpals are numbered from one to five in Figs. 4, 6, and 7.

The bony structure of each finger consists of three small bones called phalanges. The thumb has but two

FIG. 8. DENTAL FILM HELD IN POSITION FOR A LATERAL PICTURE OF A PHALANX OR PHALANGEAL JOINT.

phalanges; therefore in all there are fourteen phalanges on each hand. The phalanges are lettered A, B, C, in Figs. 4, 6, and 7.

These phalanges are numbered or named according to their position as follows: A is the first or proximal phalanx and is the one articulating with the metacarpal; B, the next one toward the periphery, is the second or middle phalanx (on four fingers, last on the thumb); and C, the third last, or distal phalanx, is the one supporting the tip of the finger and the finger nail. Phalanges are classed as long bones.

Each phalanx consists of a shaft with a proximal and distal extremity (marked D for distal and P for proximal as on some of the metacarpals and phalanges in Figs. 4 and 6). At each extremity there are joint surfaces except on the distal extremity of the third,

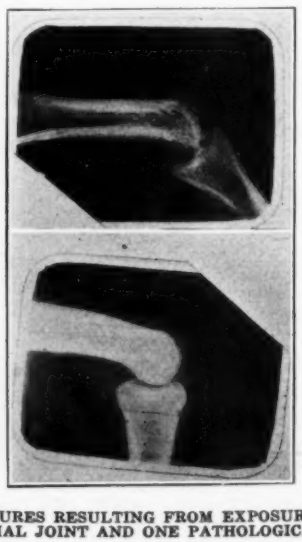


FIG. 9. PICTURES RESULTING FROM EXPOSURE IN FIG. 8. ONE NORMAL JOINT AND ONE PATHOLOGICAL JOINT.

which shows a bush or cap-like formation due to a slight spreading and some roughening of the tip. In certain diseased conditions this bushing and roughening is markedly accentuated. The phalangeal joints are hinge joints.

Usual Views Required

The usual views required for x-ray examination of the fingers are: 1. Antero-posterior: 2. Postero-anterior. 3. Lateral. 4. Antero-posterior oblique. 5. Postero-anterior oblique.

1. The antero-posterior view is very easy to obtain (Fig. 5).

2. The postero-anterior view is very easy to obtain (Fig. 3).

FIG. 10. LATERAL VIEW OF INDEX FINGER AND SECOND METACARPAL.
With slight change this posture would give a correct antero-posterior view of the first metacarpal or would give a good oblique view of the phalanges and metacarpals, if the tube were tilted or the wrist slightly twisted, etc., or a lateral view of the metacarpals may be taken in this position.

3. The middle or distal phalanges are easy to picture in the lateral position, but the proximal phalanx is sometimes very difficult to obtain regardless of the method used, especially the proximal phalanx of the middle and ring fingers. If the case is very exacting and an absolute lateral is required, it is probably best to use a dental film and hold the other phalanges out of view as well as possible, using one dental film for each phalanx (Figs. 8 and 9).

For ordinary work, however, it is only necessary to spread the fingers as well as possible and while holding them in this fashion to make the exposure (Figs. 10 and 13). The resulting picture will show those closest to the plate the clearest, and those farthest from the plate the poorest, but for ordinary fracture work it is sufficiently clear for all practical purposes.

To demonstrate bone pathology or joint change, however, the clearest view obtainable is the one of necessity. An oblique view is often an aid in demonstrating the pathology in certain cases. It may be a postero-anterior oblique through the back of the hand with the little finger and fifth metacarpal nearest the plate, or an

FIG. 11. SLIGHTLY OBLIQUE METACARPALS.

antero-posterior oblique through the palm of the hand, small finger on the plate as in Figs. 13 and 14.

X-ray Examination of the Hand

When one orders an examination of the hand he generally expects an examination of all the bones of the hand including the phalanges, the metacarpals, and the carpals. The examination of the phalanges has been considered previously.

Examination of the metacarpals: there are five metacarpals arranged laterally side by side. These form the bony support for the structures of the hand, and the distal extremity or head articulates with its adjacent phalanx.

The metacarpal of the thumb is the first metacarpal, the one for the index finger is the second metacarpal, the one for the large finger is the third metacarpal, the one for the ring finger is the fourth metacarpal, the one for the small finger is the fifth metacarpal (see Figs. 4, 6, and 7).

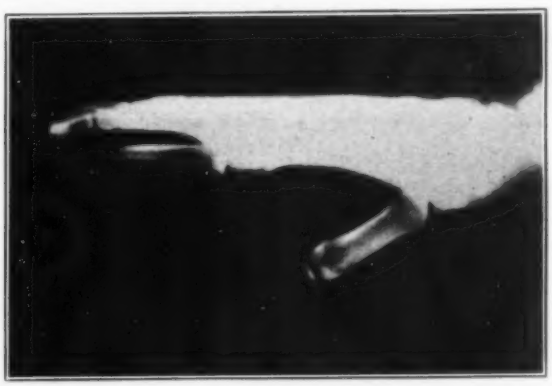


FIG. 12. LATERAL METACARPALS.

The metacarpal consists of a proximal end or base which is the carpal end. It has a shaft somewhat longer than the shaft of a phalanx, and this shaft is bowed slightly forward. The phalangeal end is called the distal extremity or head.

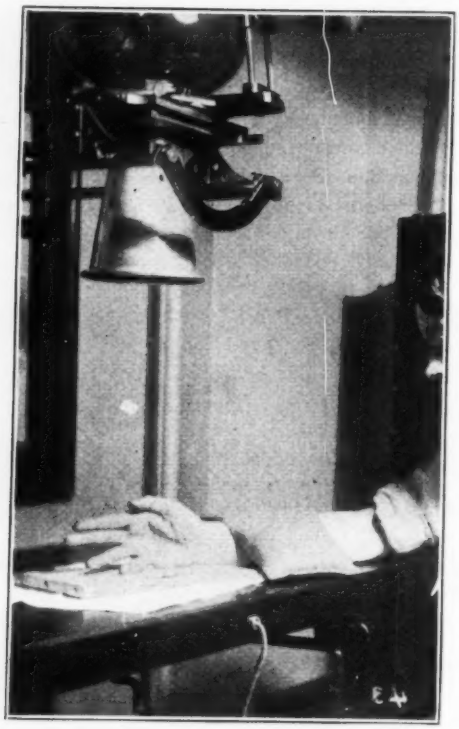


FIG. 13. LATERAL LITTLE FINGER AND FIFTH METACARPAL; SAME POSTURE MAY BE USED FOR ANTERO-POSTERIOR OBLIQUE OF THE METACARPALS.

To x-ray the metacarpals one should obtain an antero-posterior or a postero-anterior view with the greatest ease (Figs. 5 and 3). If an absolute antero-posterior or postero-anterior of the first metacarpal is desired it is necessary to take it singly.

The antero-posterior is probably the most satisfactory of the two views, as it will show the entire shaft, including the base of the bone and its joint. This is taken by placing the hand in such a way that the central ray is directed through the thenar eminence and the dorsum of the first metacarpal is resting on the film. Figure 10 is a fairly good view of this position.

To obtain a lateral view of the individual metacarpals is about impossible, with the exception of the first metacarpal. It is easy to obtain this one laterally, by placing the palm down, slightly arching the palm of the hand from the plate, and pressing slightly downward on the thumb side (thenar eminence), thumb extended and finger-tips resting on the plate.

To obtain a lateral view of the second and third, fourth and fifth metacarpals, it is necessary to superimpose one upon the other except for the slight separation due to the arching of the palmar aspect of these bones.

For fracture work if only one is fractured, the absolute lateral (Fig. 12) is often the best, but if there are many fragments due to several fractures, as in crushing or tearing injuries, it is often impossible to identify the fragments properly and in this case a view which is

FIG. 14. LATERAL PHALANGES.

slightly oblique is preferable; take stereoscopic pictures in this position.

The antero-posterior oblique through the palm of the hand is the most desirable because the palmar arch will cause the least interference with this view.

For injuries or pathology of the fourth and fifth, the antero-posterior oblique with the small finger on the plate is best (Fig. 13).

For injuries or pathology of the second and third, the antero-posterior oblique with the thumb and fore-finger or index finger resting on the plate, is best (Fig. 10). A slight tilt of the tube for these positions is often a great help, as it will aid in separating the bones without causing unnecessary twisting of hand and wrist, which may cause considerable pain.

In the postero-anterior view it is not quite so easy to demonstrate the base of the bone (its proximal end) and the adjacent joint, because of inability to place the film sufficiently high into the palm of the hand. However, for the distal portion of the shaft and the phalanges, the position is very good and very easy to maintain.

Editor's Note: The third article in this series will appear in the July number.

THE NURSE

"Like unto an angel,"
It is most truly said,
The white-clad nurse who ministers
Beside the sufferer's bed;
Who peace and strength and comfort brings
To souls and bodies weak,
And lends her aid to lure back health,
That boon the ailing seek.

The nurse assumes her patient's cares,
Her own needs sets at naught,
When through the days, and oft'times nights,
Relief is sore besought.
With quiet mien about her work
In mercy sweet she goes,
Allaying pain and soothing ills,
Inveigling calm repose.

Her training, broad and rigid,
Imparts a courage rare,
The will to do the arduous task,
Nor shirk the slightest share.
And "like unto an angel,"
As messenger of cheer,
She aims to do the Master's will
And gain rich merits here.

—Mary Josephine S. Harkins.

Three Unusual Obstetrical Cases

Alexander H. Schmitt, M.D., Chief of the Obstetrical Division, Misericordia Hospital, New York City

IN A LARGE obstetrical service, such as we have at Misericordia Hospital, New York City, where during the past four years we have had a yearly average of 1,329 deliveries, one is certain to meet unusual or atypical cases.

In this short paper I wish to report three cases occurring in my service during the year 1924. Two are highly instructive, while the third is extremely interesting.

Case No. I. F. M., age 44, single. Admitted to the service November 16th, 1923. A diagnosis of a large abdominal tumor had been made prior to admission. Her family history has no bearing on the case. Patient had never been seriously sick, never operated upon. Her periods began at the age of 17—28-day type—lasting three to four days, with but little discomfort. During the past two years her periods have been irregular and scant. Her only complaint was a progressive enlargement of her abdomen and she attributed the absence of menstruation to the onset of the menopause.

What Examination Showed

The physical examination on November 18th, 1923. presented the following: patient was well nourished and well developed and appeared in excellent health. Tonsils, atrophied. Teeth in poor condition, pyorrhoea.

Chest expansion good, respiratory murmur within the range of normal, no rales. Heart sounds of good quality, no enlargement of the heart, action regular, no murmurs. Pulse rate 84. B. P. S. 110, B. P. D. 80. Breasts are pendulous. No breast changes whatsoever suggestive of pregnancy. No colostrum expressed from the nipples.

Abdomen on inspection and palpation: uniform enlargement of the abdomen, corresponding to a full term pregnancy. Few striations present. Linea nigra not present. On palpation a large tumor could be felt, extending up near the ensiform cartilage. Contour of tumor irregular with many nodules throughout. Due to the nodulations of the tumor, foetal parts could not be distinguished. Foetal movements could not be felt; neither had the patient felt life. Foetal heart not heard.

Vaginal examination: Chadwick sign present, but the congestion of the mucous membranes was not marked. Cervix was palpated with great difficulty, as it was well underneath the symphysis on the left side. It was rather hard and not suggestive of pregnancy. A large, firm, tumor mass, perfectly smooth, occupied the whole pelvic cavity. Due to this tumor, ballottement could not be obtained.

Uncertainty of the Case

In view of these facts it was absolutely impossible to say with certainty whether pregnancy existed. A positive diagnosis of fibroma uteri could be made, but apart from the amenorrhea there was no other symptom or sign indicative of pregnancy. The question to be decided, therefore, was, were we dealing with the menopause with large fibroma uteri, or was this a case of pregnancy with multiple fibroma uteri as a complication?

As it was absolutely impossible to settle this question with certainty, from the subjective and objective findings, we resorted to the x-ray and obtained the following reading: "Radiographic picture of the uterus visualizes a foetal skeleton of about an eight month gestation, with occiput present just below the level of the iliac crest."

It was thought best not to interfere until patient showed the first signs of labor. She was kept under observation, in the antepartum ward, and occupied her time by doing light sewing and folding bandages. Her urine at all times was negative. Red blood count 4,000,000; hemoglobin 85 per cent. Apart from her mental depression she enjoyed good health.

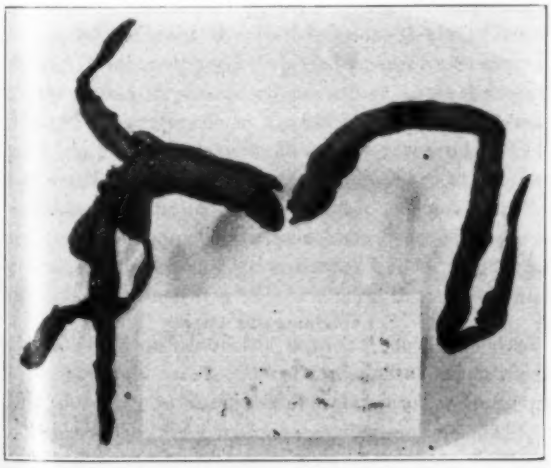


FIG. 1. PULMONARY EMBOLISM DUE TO THROMBOSIS IN THE ILIAC VEINS.

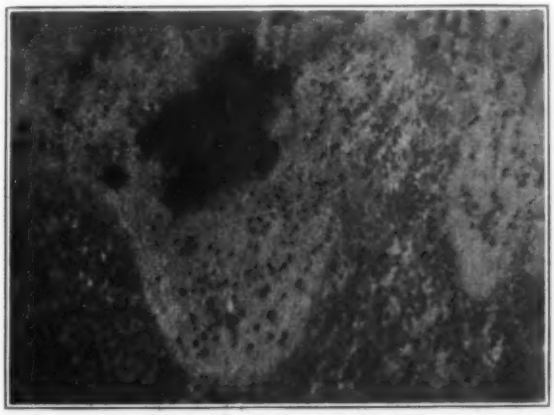


FIG. II. PHOTOMICROGRAPH SHOWING ARCHITECTURAL STRUCTURE OF THE THROMBUS.

On the morning of December 30th, 1923, at about 6 A. M., patient complained of slight labor pains, with a moderate show. At 7 A. M. membranes ruptured and pains became more frequent. Seen by me at 10 A. M. and upon vaginal examination I was unable to reach the cervix. The whole pelvic cavity was occupied by a smooth cystic mass, pushing cervix up out of the true pelvis.

The Operation

Patient was prepared for a laparotomy, which was begun at 3:30 P. M. under ether anaesthesia. Median, incision about six inches long. On opening the abdominal cavity, we found the uterus to be completely composed of a mass of fibroid tissue. There was hardly a remaining part of the womb which contained uterine tissue. The large cystic mass occupying the true pelvis was part of the uterine tumor.

Uterus was found to be larger than that of a normal full-term pregnancy. Longitudinal incision about five inches long was made through a part of the uterus which contained fewer fibroids, and the child grasped by a foot and delivered. Cord was clamped and cut. Baby resuscitated. Supra-vaginal hysterectomy was then performed by the clamp method, and the stump cauterized and sutured. The cut ends of the broad ligaments were sutured together, thus controlling all hemorrhage. Abdominal wound closed in the usual manner. Operation was completed at 4:15 and patient left operating room in excellent condition. She made a rapid and uneventful recovery and was able to leave the hospital January 20th, 1924.

Specimen which was removed at the operation consisted of the uterus, whose walls were studded with large intramural fibroids; the one dipping into the pelvis was soft, showing a central necrosis. Specimen weighed eleven pounds and eight ounces.

Conclusion: it seldom happens that one is forced to resort to the x-ray for a diagnosis of pregnancy in the latter months. In fact, this was my first experience in which I could not make a positive diagnosis of pregnancy six weeks before labor. Certainly the symptoms and signs for pregnancy were negative rather than positive. After definite diagnosis was made, there was only one line of treatment, viz., abdominal Cesarean section, followed by a hysterectomy.

Another Patient

Case No. II. M. S., age 44, married. Had two children. Last child born 13 years ago. Patient has never been seriously sick—had no operations. First day of last period, December 12th, 1923. She was admitted to the hospital on September 9th, 1924, with a history that the membranes had ruptured early that morning. On examination by an intern, cervix was found to be thick and two fingers dilated, with a face presentation. Labor pains were irregular and very weak.

Seen by me next morning, and although patient had some labor pains during the night, cervix was still thick and two fingers dilated. A diagnosis of face presentation with chin posterior was reaffirmed. Foetal heart not heard. At 10 A. M. I introduced a No. 5 Voorhees bag, and soon thereafter labor pains became more frequent, stronger, and of longer duration. At 3 P. M. bag was removed and on examination found cervix to be fully dilated, but the face was impacted in the pelvis and the chin still posterior. Under ether anaesthesia, impaction was released, followed by a difficult version and breech extraction. Stillborn child, weighing nine pounds, twelve ounces. Patient returned to ward in excellent condition. Her puerperium up to September 18th, 1924, was absolutely normal; in fact, her general condition was unusual for a woman who had gone through such a difficult labor. At no time during this period did her temperature rise above 99 degrees, nor her pulse increase above 90. Her abdomen at no time was distended, nor did she complain of any discomfort. Her uterus was involuting rapidly; the lochia was scant and serous.

An Unexpected Outcome

On the afternoon of September 18th (eight days after delivery) she was seen by me and appeared in excellent health. Pulse 78, temp. 98.6 degrees, resp. 22. Uterus was well involuted and there was no tenderness whatsoever; no edema about thighs or legs. She asked me if she could get out of bed but I told her it was entirely too soon. At 4 P. M., one hour after I had seen her, the patient called for a bedpan. She voided about fifteen ounces of urine. Just as the nurse was about to remove the pan she noticed that the patient was markedly cyanotic, shaking her head and hands as if in great distress. Her skin became cold and clammy. Respiration shallow (four to five per minute). Pulse rate 40 to 50—weak. Cyanosis became very intense. Before an intern could be summoned, patient had died. A diagnosis of pulmonary embolism was made and we were fortunate in obtaining a post-mortem examination.

The interesting features of the necropsy findings were the following: "Chest: pericardial cavity and heart showed no abnormalities, excepting that the foramen oval was patent. Aorta smooth. The pulmonary artery at its bifurcation was filled with a thrombus which extended into both branches for a considerable distance. When pieced together, the thrombus measured about twelve inches in length and averaged about three-eighths of an inch in diameter (see Fig. 1). The left lung was quite well collapsed. The right lung was held to the chest wall by old adhesions. There was a moderate edema of both lungs. Microscopic examinations of all the organs were normal and negative, but the section of the embolism in the pulmonary artery showed the usual architecture of a thrombus."

Explaining the Case

Conclusion: There is absolutely no doubt in the mind of the pathologist that this blood clot was of an ante-mortem formation and not a post-mortem (see Fig. 2). The clot, we believe, originated in the internal iliac veins as result of trauma caused by the impacted face presentation or the injury resulting from the version and breech extraction. This thrombus remained at the

point of its formation but probably enlarged until the eighth day after labor, when it broke loose and entered into the inferior vena cava and then into the right chamber of the heart as an embolism. It then passed out of the right ventrical into the pulmonary artery and became lodged at the bifurcation of this artery, extending into both of its branches and immediately causing a stoppage of the pulmonary circulation, with instant death.

An Unusual Type

Case No. III. C. M., age 20, single. Patient admitted to the institution January 1st, 1925, at about 9 P. M. The history of her labor is extremely interesting. She had at no time during her pregnancy been under the observation of a physician. Up to the onset of labor, she had been working in a factory and living by herself in a boarding house in Brooklyn.

On the night of December 31st, 1924, at about 8 P. M., her labor pains began, but not knowing just what they meant she summoned no one. Pains continued throughout the night and at about 8 A. M. the following morning, January 1st, there was a spontaneous birth of her child.

Either through fright or shame, she called for no one, but following her maternal instinct she sat up in bed, picked up her new-born infant and bit off the umbilical cord at a level with the abdominal wall. The biting off of the cord undoubtedly caused a crushing of the blood vessels, which prevented a fatal hemorrhage of the infant. She then laid the baby by her side and remained in bed without calling for aid.

Hospital Care and the Result

During the late afternoon the landlady heard the cry of the infant and upon entering the room discovered the condition. She immediately advised the girl to leave the house, and go to a hospital. The young mother got out of bed, dressed herself without assistance, wrapped the baby in some old cloths, walked down two flights of stairs to a taxi-cab, and ordered the driver to take her to the Misericordia Hospital, in New York City.

Arriving at the hospital, she stepped out of the taxi and walked into the hospital with her babe in her arms. The Sister at the door immediately realized her condition, placed her on a stretcher, and had her taken to the delivery room. It was then discovered that the placenta had not yet been delivered. This was easily expressed. Patient also had a third degree laceration, which was immediately repaired. The baby was apparently in a good, healthy state. There was no bleeding from the umbilicus, so nothing further was done.

Both mother and baby made a rapid and uneventful recovery, the mother at no time having a temperature. Perineal laceration healed with complete satisfaction. The patient's mother was notified and on the tenth day after delivery she called at the hospital and took her daughter and the infant to her own home in Brooklyn.

Conclusion: This case has no real scientific value but it is so unusual I thought it would be interesting to report. You might have read of similar cases when the caravans were making their trails toward the West, but one would never think that it could happen in the City of New York in the year 1925.

The Emergency Hospitalization of Tornado Victims—How the only Hospital in Murphysboro Met the Situation

Ray B. Essick, M.D., Murphysboro, Ill.

On March 18th at 2:30 P. M., the city of Murphysboro, Illinois, was visited by one of the most, if not the most, devastating tornado in the history of the country. The gale, lasting probably four minutes, had a velocity which has been variously estimated at 200 to 400 miles an hour. Houses of the strongest construction and supposedly tornado-proof, in the main sweep of the storm went down like so many cards. Many apparently removed, while not demolished, were later found to have suffered from the suction in the wake of the storm, and some 154 city blocks were completely destroyed by wind and fire. The monetary loss will probably exceed $4,000,000. Of 2,200 homes in the city, 1,140 were completely destroyed either by wind or fire, or both.

The immediate storm period presented all the phases of the elements; first a terrific wind; then hail, a blinding rain, and sunshine that is not surpassed in brilliance on any summer day. All this in the incredibly short time of four minutes.

Falling and fallen debris in the streets precluded any automobile traffic and as soon as the wind would permit, throngs began pouring out of buildings searching for their homes and families. With distraction on every hand, and the sun shining brightly, it seemed as if the elements mocked the populace in its plight. Everyone's first purpose was to see to his own family. These found to be safe, or the nature of their condition satisfactorily ascertained, everyone's thoughts were turned to caring for the injured and dying.

St. Andrew's a Refuge

At this time, naturally, all eyes turned toward St. Andrew's Hospital, which on so many occasions had proven a haven for those in pain. But the impassibility of the streets made it necessary to improvise dressing stations and hospitals until such time as the streets could be cleared for the ambulances to move. Those on the outskirts of the storm and those who could walk, immediately made their way to the hospital. Others were taken by stretchers, doors, ironing boards, etc., to the nearest standing building, that they might receive temporary relief. The high school building, the Elks' home, the Eagles' home, and the Masonic home were soon filled, and such physicians as could be obtained were promptly among them administering to their wants. In only a short time these places were functioning as first-class emergency stations.

The hospital, normally a fifty-bed institution, was soon filled, and 180 had been admitted by 10 P. M. Among these were about sixteen children, not injured but homeless and separated from their parents. Volunteer aid among the women of the city helped in their care.

As the patients arrived, work began in the operating rooms and on make-shift tables throughout the hospital. During the first twenty-four hours operations included eighteen limb amputations, nineteen decompressions, three laparotomies, ninety reductions of fractures, eighty-seven plaster casts, wiring of one jaw, plastic operation of one face, suturing of 210 wounds. In the course of the first night sixteen died, primarily of shock from the storm and secondarily as a result of the operative work. All this was done practically in spite of the fact that all utilities were suspended; there were no lights, water, or gas. Ether anaesthesia was being administered in many places by candle and lantern light. The risk was momentarily forgotten in the exigency of the time. Many of the fracture cases were put up with a view to immobilization at the time rather than approximation, the need for future operative interference being noted.

A VIEW OF THE IMPROVISED HOSPITAL IN EAGLES' HALL, MURPHYSBORO, ILL., SHOWING SOME OF THE MANY VICTIMS OF THE TORNADO.

The hospital has a staff of sixteen Franciscan Sisters, of whom ten are in the nursing department and the remainder divided between office and kitchen work. Notwithstanding, when the patients began pouring in, all became nurses for the time. Every Sister was on continuous duty for forty-eight hours. Those employed in the operating corridor had but six hours' rest in seventy-six.

Utilizing All Available Space

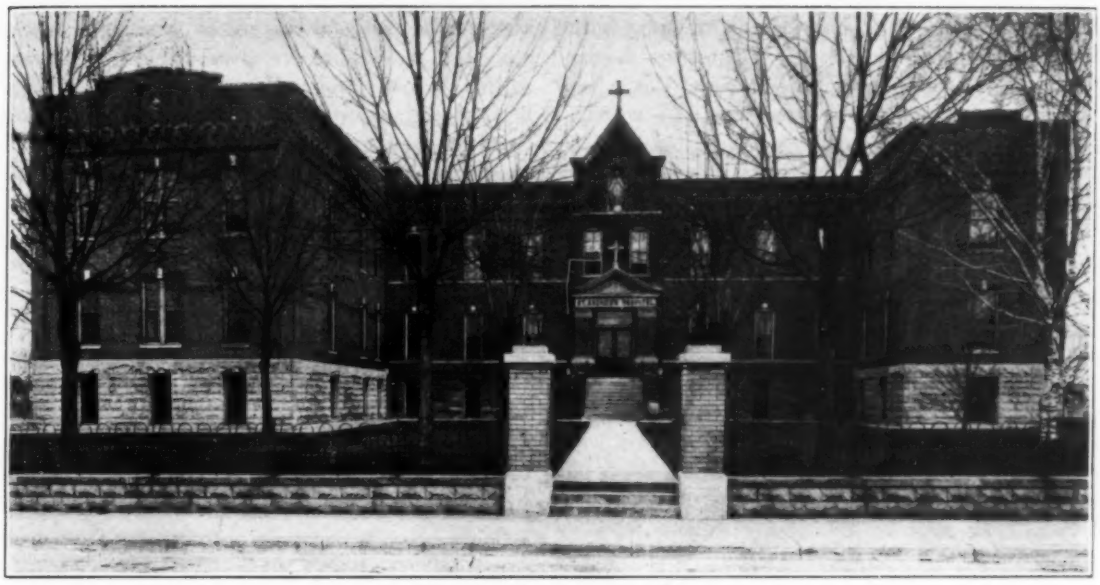
The rush of patients was so great that such rooms as were available, in view of the fact that there were thirty-five patients in the house at the time, were filled with the first ambulance trip. As the ambulances came in with six and eight at a time, the drivers related that it was impossible to keep the people from loading the injured and dying. It was necessary that the hospital management ask the ambulance men to give them the benefit of the doubt as to those dying and dead, and to take such victims to the morgue to minimize the congestion.

Soon after the storm, squads were organized to clear certain streets, that the injured might be taken to the hospital. This greatly facilitated the work, and every available space was used at the hospital. Forty were placed in the laundry room, twelve in the sewing room, three in the storeroom, four in the boiler room, and twelve in the basement hall. The corridors were filled, with the exception of a small aisle through which a person could pass. Several were placed in the laboratories and wash rooms. After midnight, when all emergency surgery had been cared for, three patients remained on the three operating tables as their beds.

Some Fortunate Aspects

The staff of the hospital is composed of sixteen physicians, who worked long after midnight equally divided among the various emergency hospitals and St. Andrew's. It was decided that certain ones should be chosen to stand watch throughout the night, while others obtained such rest as they could, since the morrow promised a very strenuous day. Fortunately the storm did not take any toll of the profession, even in slight injuries. Though some of the doctors suffered property damage of varying extent, and injuries among members of their families, they themselves were providentially spared to administer to the less fortunate.

Neither did the hospital suffer seriously from the storm, although several windows were blown in and most of the roof was carried away. In one room the



ST. ANDREW'S HOSPITAL, MURPHYSBORO, ILL.

surgeon operated while the rain beat in upon him, thoroughly drenching the patient and all. At 6 A. M. on the morning following the storm, a relief train from Chicago arrived carrying nurses and physicians.

By this hour all surgical supplies and dressings in the city had been utilized. But the relief corps rapidly replenished these, and various supply houses were quick to sense the need and send large quantities of dressings. When food supplies began to dwindle after the first twenty-four hours, a great and very welcome surprise came in the form of one hundred cakes and two hundred loaves of bread which some one had brought to the storage room of the hospital. This room opens onto the street and as yet the gracious donor has not been located.

Charitable Ministrations

As the night of the 18th wore on, the fatal cases began to manifest themselves, and Father Robert De Gaspari, assistant in the parish, went about administering spiritual succor regardless of creed or race. Many of the dying were without the comforting presence of relatives. Under these trying conditions the women of the city assisted in every way, preparing meals, quieting restless children who were separated from their parents, and performing other works of charity. For several days eighty persons were fed in the hospital, exclusive of patients and employees.

The local public utilities company gave its first efforts to securing water, lights, and gas for the hospital. The night of the 18th, local automobile men furnished lights in the operating rooms and corridors by means of storage batteries. By noon of the 19th these commodities had been restored. A special wire was strung from the light plant to the hospital for light. The surgery of the 19th consisted largely of decompressions and amputations. These were considered of the most import at the time. On the days following, the lesser cases received attention, fractures predominating.

At noon on the 20th, the Rt. Rev. Althoff, Bishop of the diocese, arrived with his secretary, as did the venerable Mother from the motherhouse, St. Anthony's, St. Louis, Mo. Accompanying the Mother were five Sisters skilled in operating room technique. This additional aid, with the nurses brought in by the relief trains, gave the members of the staff and the regular hospital Sisters a much needed rest.

Faithful Preservation of Records

Despite the confusion and rush on every hand, complete records were kept from the beginning, of those dying in the hospital and the disposition of the remains. An office force kept a daily record of the cases for the benefit of the press and those inquiring for their friends and relatives. Every courtesy and aid was extended those searching for missing ones.

During the first few days following the storm and before evacuation of the emergency stations began, the x-ray department made 125 skiagrams and more than 218 exposures. These were all carefully indexed and are available now as reference cases. Two salesmen representing x-ray firms assisted the regular technician in this work. The staff and the Sisters gave every possible care and attention to the injured, and physicians in turn stood night watch for two weeks following the storm.

While the mortality rate was high in amputation cases, it is remarkable that any made a recovery under the conditions attendant upon the operations. Despite the infections and limited conveniences, infections did not become general in the hospital. Within ten days the operating rooms were functioning full time, as before the storm. All rooms which had had gas infections received fumigation immediately following removal of the case, and the operating rooms received two fumigations. Laparotomies done five days after the storm have made uneventful recovery. Two cases of erysipelas developed and were isolated in the house without infecting others. One case of scarlet fever developed in a

child who had been in the house prior to the storm, without subsequent cases appearing. This serves to convince us that absolute control over cases of this nature is possible. The scrubbing squad was busy continuously. At times it was a volunteer force, but on Sunday following the storm six Sisters worked at this menial task from 8 A. M. to 5 P. M.

The Remnants of Catastrophe

On March 21st things had quieted down enough to permit of the disposal of some cases. This was made necessary by reason of the fact that the emergency hospitals were not properly equipped for sanitation. On this date four were taken to Chicago and on the 20th eight were taken to East St. Louis, Ill., and fourteen to St. Louis. On the following Wednesday nineteen went to St. Louis. With these disposed of, room was available for those who could be moved from the emergency stations, and thus these stations were relieved of their daily mounting risk.

This terrible catastrophe has served admirably to cement the bond of regard which has always existed between the citizens and St. Andrew's regardless of creed. Visiting surgeons and nurses who came to us from all points within a radius of 500 miles have been loud in their praise of this institution. They have marveled at the system of management that was worked out so soon after a holocaust of this nature. Visiting nurses and physicians had but to announce themselves as such to receive every courtesy and consideration at the hands of the hospital authorities, and this regardless of ability. Even excellent meals and provision for rest were prepared for these out-of-town physicians and nurses.

The Good Work Goes On

As an expedient of the times the hospital management has declared its doors open for maternity cases in which the expectant mother is deprived of home surroundings or while her home is under construction. At this date all repairs have been made at the hospital and it is again functioning as of old. Only a very few cyclone cases remain.

The terrible calamity is but history to the Sisters. The horrors of that first night, which have been compared to the battlefield of France, will long be with them. But with glad hearts would they give the same service again if it were necessary. Citizens today, when they recall the storm, always make mention of the fact that had it not been for St. Andrew's Hospital, the suffering and deaths would have been greatly increased. If ever a hospital had a baptism of fire this institution has just passed through that stage, and when the history of this vicinity is written, a large portion of it must be dedicated to the part taken by St. Andrew's Hospital in the tornado of March 18th, 1925.

An Appeal to Hospital Staffs for Early Consideration of Neurosyphilis[1]

G. G. St. Clair, M.D.

THE WORK of the Veterans' Bureau, which I left a year ago, gave me an excellent opportunity for the study of cases in the light of a real follow-up. The men had all been examined by a number of different physicians in various cities, and returned again and again to have our observations added to their files. Time has a thorough manner of uncovering our mistakes. I was strongly impressed with the fact that the important conditions most frequently overlooked by the rank and file of us, strange as it may seem, were the late manifestations of syphilis, the most tragic being those afflicted with neuro-syphilis. The series was not large, but was sufficient to bring home forcibly, not only the inadequacy of the treatment given before discharge, but also the large amount of treatment which could still prove inadequate. In nearly all there had been no examination of the nervous system (cases were cited).

During my recent studies at New York and Rochester, I made an effort to pick up points which would enable me to clear my conscience in regard to these tragedies. Realizing my shortcomings, upon my return I decided to canvass the local situation.

The record room of this hospital found in the 1924 file, seventeen cases classified as lues of the central nervous system. Of these, three had no spinal fluid tests, and we could find records of only two intra-spinal treatments.

It is not probable that many of us are sufficiently adventurous to do many spinal punctures outside of the hospital. Apparently we have suffered more or less from the assumption that neuro-syphilis belongs to the neurologist. I am convinced, however, that it is the business of every man who ventures to treat the disease in any form. Hence this paper.

Interesting Statistics

Statistics are as often exhausting as they are exhaustive, but I must quote a few to answer the following questions:

1. How frequent is clinical neuro-syphilis?
2. How often does syphilis of all types recover spontaneously or with a little treatment?
3. What, briefly, is being accomplished by modern treatment?

In my reading I found, as usual, that a good way to get statistics in a nutshell was by reference to Osler's Practice. He quotes four thousand cases followed over a period of twenty to thirty years, and finds that of these, four and seven-tenths developed paresis; three and two-tenths cerebro-spinal lues; two and seven-tenths tabes dorsalis; and that these figures vary directly with the amount of treatment received. Hazen says that eight out of every one hundred cases of syphilis affect

[1]Delivered March 5th, 1925, before the staff of St. Mary's Hospital, Duluth, Minn.

the nervous system. Stokes says that complete symptomatic and serologic arrest occurred in less than one per cent of two hundred and eight untreated cases, and in only six per cent of those treated by mouth. He says that neuro-syphilis is *not* more frequent in cases treated inadequately by the modern method but only apparently so, because it is relatively more resistant than lesions of viscera, etc. He concludes that, though time and rest are extremely important factors, "it is absolutely necessary to reinforce the natural defence by modern treatment."

In an analysis of 405 cases of all types of neuro-syphilis treated radically, Stokes reports a practical return to normal in 90.9 per cent of meningeal syphilis; 74.5 per cent of cerebro-spinal lues; 48.3 per cent of tabes; and 38.9 per cent of vascular neuro-syphilis; with improvement in still more, and hopeful signs of partial arrest in preparetic cases. It is obviously too soon to report permanent arrest in any series. But from all quarters are reported well observed cases which under vigorous intravenous therapy have passed through the stage of a negative spinal Wassermann, but a slightly high cell count, to a positive Wassermann and a well developed tabes or paresis. There is an increasing number of equally well authenticated cases with similar findings which have been spared this result, apparently by intra-spinal treatment.

As I understand the vast literature on this subject, the men who are most optimistic about their results are those whose spinal fluid control begins earliest and whose treatment is most radical. They are also the ones who point most confidently to their follow-up.

Some Accepted Premises

The modern attack on the problem of neuro-syphilis is based on the following accepted premises:

1. The earliest pathology of the nervous system in syphilis is found in the meninges.

2. The spinal fluid gives evidence of this invasion very early in the disease. Rosen says that of all luetics seen with secondary manifestations 25 to 30 per cent have spinal fluid evidence of syphilis. A high cell count is very constant and usually present before the spinal Wassermann is positive.

3. The blood Wassermann is relatively of little value in neuro-syphilis. The spinal fluid may be positive long after the blood is negative. The "Wassermann-fast" case is often an asymptomatic C. & S. lues.

4. The gold curve may early give a lead as to the type of parenchymatous change impending.

5. Warthin, Wile, and others have unquestionably found spirochetes in the spinal fluid.

6. It is logical to place an effective arsenical in contact with those organisms wherever found.

7. It is also logical, in view of the question as to the amount, if any, of arsenic which enters the spinal fluid after intravenous administration, to augment this treatment by direct introduction into the fluid.

8. Spinal drainage has been found to have no curative value.

Procedure at Mayo Clinic

The men at the Mayo Clinic are quite likely to combine a great deal of general wisdom and common sense with their scientific handling of cases. Briefly their plan of early attack on syphilis with reference to the nervous system is as follows:

The spinal fluid check-up is carried out never later than the second course of arsenical in any case. All patients seen first during the second stage, and all hereditary cases, are checked up during the first course, after the massive spirochaeticemia is under control. Intraspinal treatment is combined with intravenous often before a positive spinal Wassermann appears. A stubbornly high cell count is considered sufficient evidence of this necessity. A count of five or more requires careful watching. They do not consider spinal puncture and intraspinal treatment any more dangerous than the intravenous method. They have confidence in the value of intravenous iodides.

The choice of arsenical is a subject on which there is much conflicting evidence, but apparently old salvarsan has not been surpassed for these cases, speaking entirely of spirochetocidal action. Tryparsamide is probably not spirochetocidal but gives promise of being valuable for its tonic and symptomatic action. Bismuth lies somewhere between arsenic and mercury in its action on the spirochaeta. Sulpharsemin may be more penetrating and is capable of intramuscular injection but the greater frequency of skin complications and purpura is a drawback to its use in private practice.

Three Methods in Vogue

While I was away, I made it a point not only to study the simple mechanics of the intraspinal treatment as given by the physician, but also to learn the part done by nurses and technicians in the far more important preparation of material. There are three methods most in vogue, which I will describe briefly. The Swift-Ellis method consists in withdrawing about 50 c.c. of blood twenty minutes after the ordinary intravenous injection of an arsenical. The blood is allowed to clot one and one-half hours, rimmed, and later centrifugated for ten minutes and the serum pipetted off. After a second centrifugation at not less than 1,800 revolutions, the serum is again pipetted off and allowed to stand in the ice-box over night. In the morning before use, it is incubated at 56 degrees for one hour and ten minutes, which inactivates the serum. Thirty c.c. of spinal fluid are then withdrawn and 25 c.c. of the serum allowed to flow back through the same needle. The fortifying of this serum by the addition of up to one-fourth milligram of salvarsan constitutes the Ogilvie modification.

A simpler method, which has been in use by Wile at Michigan for years, consists in withdrawing 10 c.c. of fluid, 5 c.c. of which are sent to the laboratory. To the remaining 5 c.c. is added up to one-fourth milligram of

salvarsan, the mixture being allowed to run back into the canal. There is considerable doubt as to how much arsenic, if any, is introduced by the first method, because so much of it is lost in the clot. The details are simply absolute chemical and surgical cleanliness, and the equipment required should be a part of every hospital. The procedure is by no means beyond the skill of any one willing to put in sufficient time to insure the accuracy of his technique.

Urging a More Vigorous Attack

No attempt has been made in this paper to present anything new to you. I merely desire to remind you that syphilis of the central nervous system exists in a stage when it is asymptomatic and therefore not recognizable without spinal fluid examination. I would urge early consideration of neuro-syphilis by every one who treats a single case. I would further urge that in all cases recognized, a more vigorous attack be made than is required by the disease in any other form. If we wait to see whether our patient belongs to the group which clears up spontaneously, he may return on crutches. If we assume that the tabetic is inevitably headed for the wheel chair anyhow, we may sleep better, but some of our patients will not.

It is difficult to persuade people to submit to spinal punctures, because they think a few negative blood Wassermanns mean a cure. But people used to die rather than admit tuberculosis, and not so long ago it was hard to obtain consent for appendectomy. No one expects as yet to cure a well established paresis or tabes, but we should exhaust every possibility of lowering our percentage of future wrecks.

It should be obvious that no one should have a spinal puncture done in which the maximum of benefit accruing therefrom should not be forthcoming. In other words, where patients are submitted to this sometimes trying test, the result must not be vitiated either by uncertainties of technique or faulty laboratory detail. There should be no contaminations with blood, so that an orderly, correct cell count may be made. While in some instances the Wassermann test may tell the whole story, there are many others in which the Nonne and the cell count and the colloidal gold are all needed for careful differentiation.

This hospital, with its laboratory extension, is now in a position to have all this work done promptly and efficiently. As far as the Swift-Ellis method is concerned, everything needed has been provided, including all the essential new glassware. A Sister technician is in charge of this equipment, and already a number of entirely successful intraspinal treatments have been given. As in many other hospital procedures, it is not only necessary that the technical equipment be available and everything standardized, but staff members themselves must know the indications and possibilities.

Problems of the Hospital Training School[1]

Sister M. Stella, R.N., Superintendent of Nurses, St. Mary's Hospital, Duluth, Minn.

THE PROBLEMS of our schools of nursing are much the same as those of the regular boarding high schools and colleges, with the exception that we must combine theoretical study with actual accomplishment. The idea that we are conducting a school of professional training should not be lost sight of for a single moment. We must set aside time for recitation and for lecture; time for practical demonstration in the classroom and the wards; time for study, recreation, and rest.

One of the greatest problems of the superintendent of today is to discover how to keep the interest of the students when they are off duty. I have talked to superintendents who have modern and convenient homes for the nurses; homes with large, well furnished reception rooms and all equipment for the comfort and relaxation of the inmates. Yet these superintendents tell me that the students, when coming off duty, just pass through these rooms and go directly to their private rooms, where they either study or take a nap. In the evening hours they go out or remain again in their own rooms. Occasionally a few groups do gather in the reception rooms, but this is rare; and even when it does occur the groups make up far from the majority of the student body.

Wholesome Diversions

Where there is an equipped gymnasium in the students' home, a larger number of nurses are interested. This year in our school we organized a basketball team which did excellent work in spite of the fact that we managed to get in very little practise, and this was in a gymnasium many blocks away from the home. We derived appreciable benefit from this experiment. Hence, I believe that the gymnasium is a partial solution of this problem. But we cannot all secure the necessary equipment right away, and until we do we are still handicapped.

A branch of this recreation question, and to my mind a serious one, is the problem of a suitable library in the nurses' home. Reading is a wholesome and legitimate recreation, if it is reading of the right kind. In going through the nurses' home I not infrequently come upon such trash that only a glance is required to prove that the furnace is the only right place for it. Upon inquiry I all too often learn that the nurse "got it from a patient"; that "everybody is reading it"; that she "can't see any harm in it anyway." If the girls come to us with the habit of good reading still unformed, it is up to us to do our utmost to instil that habit now into their minds and their hearts. Once out of school it is too late. Then they will be forever unconscious of improper reading because they have never been guided in

[1]Read April 14th before the Minnesota-North Dakota Conference of the C. H. A., St. Joseph, Minn.

their choice of books nor taught true standards of good literature.

But why all this talk about recreation for student nurses? Simply because, in my opinion, if we can get our students in a happy and contented frame of mind, if we fill their recreation time with pursuits which are wholesome and yet do not take them out of the home, we will make them contented in their environment; they will earnestly attack their studies; and their practical work will be a pleasure to them. As it is, there is too little to attract them here. Consequently they are always seeking late permits, and both their work and their studies suffer.

The Seriousness of the Profession

The young girl of today, when deciding upon nursing as a profession, does not realize the amount of real study and responsibility connected with the step she is about to take. Even yet we still hear the old saying, "Any one can take up training to be a nurse." It is both interesting and illuminating to hear a group of student nurses talking over what they thought about training before they went into it. Recently a young girl was heard to remark, "I had to take up training. I couldn't get enough credits to finish high school, although I attended ours for four years. I guess I haven't brains enough for anything else." I assure you that this probationer never received the uniform.

One of the most difficult of the hard tasks the trainer has before her in the education of these young people, is making them aware of these things. It seems impossible with some of them to make them feel a personal interest and responsibility both in their tasks and in every part of the house. Most of them have had absolutely no responsibility before coming to us. Even their school work never bothered the majority of them very deeply. "We should worry, so long as we get through," seems to have been the slogan of practically all of them. If prior to her entering training she has had experience in practical economy; if she has learned the value of things; if she knows the cost of mere living —why then half the labor of the hospital and training superintendents, of the floor supervisors, and of all concerned with the hospital, is saved. The cost of running our hospitals, moreover, would be at least half of what it now is, if the student nurses took that keen, personal interest in the things of the hospital that any well brought up girl takes in her own home. But many of these girls have no sense of economy; they do not seem to know what the term implies. They should be alert, too, to save time; when an emergency arises they should use their heads instead of their feet, as most of them do. Economy, in all its ramifications of meaning, should be ground into them. But—how?

Discipline

A third problem is that of punishment. When a student offends, what should be the penalty? It is well known that there is no use in making rules and regulations unless the offender be penalized; yet there is just criticism hurled at practically every one of the few punishments usually employed: suspension for a month or two at the home or sending them to their own homes for that period of time; taking away their cap and bib; denying them late permits; campusing. The latter two work with some students, but with others to whom late permits and off-campus permits mean nothing, of course the curtailing here is meaningless. Removing the cap and bib is said to have a deteriorating influence upon the hospital, for patients lose their confidence in nurses so penalized. And as for suspension, it can only be employed in extreme cases if it is to be at all effective. Yet in this day and age, when youth is so careless and forgetful, we cannot let pass the many transgressions committed by the student nurses.

Selection of Applicants

But prior to all these problems of recreation and discipline is the question of selection of applicants. The alumnae are the best advertisement for the training school. If their days were happy, their training efficient, and they are today a success, they will do much both by word and by example to influence others to follow in their footsteps; they will be the stimuli for many applicants. In each case, however, whether the applicant be highly recommended or not, the superintendent should interview her personally and not allow the recommendation of another or the mere application letter to take the place of that personal interview.

Allied with this question is another practical one which is difficult to answer. After applicants have been received and are being tried out, I often find that a girl is very skilful in the practical side of her work, and yet continues weak in the theoretical; or is brilliant in theory and poor in technique. It is very difficult in such cases to determine who should be dismissed and who should be retained.

Of course in all cases the applicant should be mentally and physically sound. Weaknesses here would be serious drawbacks. And the superintendent must exercise the utmost care in seeing whether or not the student is adapted to the work, for this is mere justice to the girl and to the school. A nurse has to be a woman of resources, of initiative; she must be tactful, gentle, and full of discretion at all times. And the superintendent must encourage her constantly along these lines.

On the other hand, the superintendent must mercilessly weed out the undesirable students. She must watch over the conversations, the conduct, the manner of meeting obligations, and so forth, of all under her care. She must show no favoritism, for that destroys the morale of any school. She must give nurses a square deal if she expects a square deal in return.

The students have rights, and it is her place to see that these rights are respected. She must aim to make them feel that they have come to the right place. She must explain the advantages of training; she must make clear all the bills of legislature bearing upon the nursing profession. She must at all times uphold the highest standards of womanhood. And above all, she must aim to make her nurses contented and happy in the home.

Just as in the private family the home is the real seat of character development, so here in the school of nursing the home should be the center of interest, of thought, of real training. Marble walls never yet made a home. But a spirit of love, of kindliness, of understanding, can exalt the lowliest abode; and rare is the worth-while girl who will not blossom out into sound, responsible young womanhood in such surroundings.

Complete Steam-Operated Kitchen Equipment for Hospitals, and a Modern Installation

E. W. Riesbeck, Consulting Engineer, Chicago

IN THIS article we shall not only describe a modern, steam-operated kitchen and go into detail on its equipment and proper connections, but where it is advisable we shall point out why in some instances where equipment of this type has been installed in the past, it has proven a failure. Reasons are given and suggestions are made which may be helpful to others in the future.

Hospitals with their ever increasing demand for service, have, wherever gas is available, turned to the gas range for cooking and the gas roaster and broiler for roasting meats. These gas appliances have served large institutions well for a number of years; they are still serving the small institutions today, and will for a number of years.

In a large, modern hospital these gas appliances have outgrown their usefulness to a great extent, because the demand placed on the institution is so great, and the room available for the kitchen frequently is not in proportion to the size of the institution, due to the fact that very often additions have been made without increasing the size of the kitchen. The quick and efficient service which hospitals are called upon to render in a comparatively short space of time, has brought about a condition in which they have been forced to adopt a better and more rapid method of preparing and handling the large bulk of food they are called upon to serve on short notice.

For the foregoing reasons the steam-operated kitchen has been developed in recent years to a point where it is economical, rapid, and more satisfactory. Food can be prepared in larger quantities at short notice and in a comparatively short space of time.

A common mistake is to make the hoods the exact size of the range or other apparatus they are to serve. The hood should be at least two feet larger in each direction if it is to serve its purpose efficiently. In the installation described, no odor is carried even to the first floor, and in the kitchen itself scarcely any odor is noticed.

Coffee Urn

The coffee urn consists of two compartments, the inner or coffee compartment, which is surrounded by an air space, and the outer or water compartment, which contains the steam coil. Cold water is piped to this compartment, a shut-off valve is provided, and waste pipe to drain. Separate gauge glasses are connected to both the water and the coffee compartments. The air space located between the two allows the outside compartment (after the water has been drawn out of it into the coffee compartment) to be refilled with cold water without cooling the coffee, which would be the case if this space did not exist. A safety valve is connected to the outside compartment to release the steam pressure at eight pounds. A separate draw-off cock is provided for each compartment.

Two coffee urns of ten gallons' capacity each, were installed, for the reason that one twenty-gallon urn would hold too much coffee at supper and dinner time. In this case only one ten-gallon urn is used. At breakfast time, when more coffee is needed than at any other meal, one urn is started first, and after this coffee is partly used the other is started, thus providing fresh coffee when the supply of the first urn is exhausted. Where tea is served one of the urns may be used for boiling water.

The steam supply connection to the coil in the water compartment is generally brought up from below on the right hand side facing the urn, and the return from the coil is generally located on the left hand side. These connections may vary in different types of urns, but great care should be exercised to connect the steam supply properly and not reverse the two connections. In quite a few instances where this had been done, it slowed the process of boiling, because the steam had to push the water out of the top of the steam coil, whereas if the connection is made properly the water will flow from the coil by gravity.

The Steam Supply

In a large number of cases the coffee urns are placed on a counter with warming shelves underneath for cups and saucers. In this case a steam coil is located under each shelf. A separate connection to these coils should be made and trapped separately if it is desired to keep the steam on the coils at all times, without running the coffee urn. In most cases this is not necessary as the cups and saucers will be heated during the time the coffee is made in the urn.

Experience has demonstrated that the most satisfactory way is to run the steam supply through the steam coil in the urn first, connect the discharge from this coil to the inlet of the warming coils underneath the shelves, and put the trap on the discharge from the lowest warming coil. When two or more urns are used the steam supply to each must be valved and the return can be connected to the warming coils by means of a header,

so that each individual urn, when in operation, will heat the warming coils underneath the shelves.

The discharge from the trap must be connected to a receiving tank vented to the atmosphere, or it may be connected to the sewer. Care should be taken that this discharge is not connected to anything that may cause a back pressure to exist in this pipe. The valve provided on the return from the coils in the urn (if the steam is connected as previously described) can be left open without doing any harm, or it may be closed without causing any trouble in the coils.

The main steam line leading into the kitchen should be pitched toward the end and trapped separately. All traps can be located on the floor in a convenient place beside the apparatus, or in case a basement is provided, they may be placed there. The return or discharge from all traps can be run upward if necessary. In the kitchen described, 40 pounds of steam are used for cooking and I found this pressure ideal for all purposes, except for vegetables, which require only three to six pounds' pressure.

Operation of the Urn

In order to locate any possible trouble we shall describe the operation of the urn, which is as follows: steam is turned on the coil in the urn and the water in the compartment is brought to a boiling point. The valve located on the left hand side controlling the spray pipe is then opened. As soon as two or three ounces of steam pressure are formed in the water compartment, the water is forced into the spray head on top and sprayed over the ground coffee in the center of the urn. From there it flows through the coffee, gathering in tne compartment below. The spray head is swiveled so that it can be swung out of the way to allow the insert, into which the ground coffee is placed, to be removed for cleaning purposes. The coffee so produced is called drip or percolated coffee and has a better flavor than coffee prepared in the ordinary way.

After the water from the outer compartment is all discharged into the coffee compartment (which by the way is enough to fill this compartment) the steam is shut off and the outer compartment may be filled with fresh water. The finished coffee is drawn from the coffee compartment by means of the faucet. This faucet, as well as the gauge glass cocks connected to the coffee chamber, should be arranged in such a way that a brush can be drawn through them in order to clean out the sediment lodging there. This is necessary for sanitary reasons.

Jacketed Soup Kettle

The soup kettle is made out of aluminum and jacketed only half way up. This method of jacketing a soup kettle is superior to a full jacket because it allows the soup to boil from the bottom. A hot or cold water connection is brought into the kettle from the top. The top of the kettle is covered and this cover is hinged in the center, allowing the water pipe to enter behind the hinged portion. Four legs are provided and riveted to the kettle. On the rear portion of the cover a flange is riveted to receive the vent pipe. The jacket has a flange on one side to admit the steam supply. On the bottom of the kettle, opposite this flange, is another to which the trap is connected. The discharge from this trap can be run upward in the same manner as described before. Steam at forty pounds' pressure enters the jacket and heats to the boiling point the contents in the inside chamber. The supply pipe to the jacket must be properly valved so that the boiling of the soup can be controlled. The finished soup is drawn from the inside chamber by means of a faucet extending into this chamber. An aluminum screen over the opening prevents the vegetables and other solid matter from entering the nipple.

If the soup kettle were jacketed all the way up, the ingredients used in preparing the soup would not boil up from the bottom and give off their flavor, because the heat of the steam would cause the soup to boil only on top. For this reason it is essential to remove rapidly all the condensation from the jacket. Many steam-operated soup kettles are not used because the chef claims the soup has no taste when prepared in the aluminum kettle. This is not the case. The reason is that water lodges in the jacket and prevents the boiling of the soup from the bottom up. The remedy for this is the installation of the proper trap to remove the condensed steam. A safety valve should be installed on the soup kettle to relieve any excess steam which may by accident or otherwise enter the pipe line, to prevent explosion or damage.

Cereal Cooker

The steam cereal cooker consists of a copper tank with a steam coil on the bottom. The inlet and outlet to this coil should be permanently fastened to the wall of the cooker. The inlet valve should be located about three feet from the bottom of the kettle so that one need not bend down to reach it, and the outlet must be connected to a trap in the same manner as described before. It is not advisable to connect all the equipment to one trap. Inside the copper tank described before, another tank is placed on a rack located on top of the coil in the bottom. This tank or cereal compartment is six inches smaller in diameter than the outer tank, leaving three inches of water space all around the cereal compartment. When the steam is turned on the water is brought to the boiling point, thus cooking the cereal in the inner compartment. This cereal cooker saves a great deal of time and attention.

Steam Roaster

The steam roaster has no doubt revolutionized the art of roasting meat. In fact, a second class roast cannot be distinguished from a first class roast if prepared in a steam roaster. The steam heat penetrates the meat thoroughly and evenly; at the same time all the meat juice is retained in the roast, flavoring it, and a delicious roast is the result.

As far as outside appearance is concerned the roaster resembles a cast-iron kettle. The only difference is that it has a steam jacket surrounding the kettle.

This divides the roaster into two compartments, the inside or roasting, and the outside or steam compartment. Steam never comes in contact with the roast. The outside compartment is again divided into two parts, the upper and the lower. The lower part has a separate steam connection and is used for roasting only, that is, steam turned on the lower part roasts the meat; when the steam is turned on the upper part the meat is browned. A drain is provided from the roasting compartment so that the meat gravy may be drawn off and this compartment cleaned and drained. Two steam connections are necessary, and two drain connections to the roaster, if one desires best results. Most roasters are connected with one pipe and one valve and this is in many cases the reason why they do not operate satisfactorily.

The operation of the roaster, in short, is as follows: the meat is placed in the roasting compartment, the drain pipe filled with water. If it is desired only to roast the meat, steam is turned on the lower part of the jacket alone; if the roast is to be browned, the steam is turned into the top part of the jacket. The valve leading to this compartment, however, must not be opened until the roast is well done, which takes from one and one-half to two hours, according to the size of the roast. Browning the roast after that takes only a half hour. If both valves are turned on at the same time the roast will brown immediately, preventing the steam heat from penetrating the meat.

Many roasters are connected with one pipe to the upper and lower chamber in such a manner that when the steam is turned on it fills both chambers and the condition previously explained prevails, making it impossible to produce a first class roast. A number of times the writer has found this condition existing and the roaster was not used for the reason that it did not produce a good roast. After the changes were made, the roaster was used more than any other piece of equipment in the kitchen.

Vegetable Steamer

The vegetable steamer is composed of a sheet-iron or cast-iron outer shell, as the case may be, and usually set on an angle-iron frame. It contains three or four compartments so separated from each other by a solid partition that each forms a unit. Each unit has a door that may be locked by means of an eccentric roller, steam-tight. This locking device is so arranged that it may be swung out of the way when the door is opened.

A rubber gasket in the door makes it steam-tight. In the compartment, about one inch from the bottom, a perforated plate is laid on several lugs to hold the basket containing the vegetables. This basket is perforated on all sides and bottom in order that the steam may penetrate to all parts of the basket and circulate around the vegetables to be steamed freely. The perforated plate referred to is fastened to the door in such a way that as soon as this door is opened the basket will be pulled out of the steamer for examination or removal, as the case may be. The steam supply to the vegetable cooker should not be more than two or three pounds for good results.

The latest type of vegetable steamer has an attachment that will shut off the steam as soon as the door is opened, thus assuring the operator safety. On the older type of steamer it frequently happened that when the operator forgot to shut off the steam before opening the door, his hands or face were scalded. This is avoided in the later type of apparatus.

The operation of the steam is as follows: the loaded baskets are placed in the steamer and the steam is turned on the compartment, circulating around the vegetables and filling the compartment completely. This causes condensation and the water is discharged through an opening on the side of the compartment close to the bottom, into a pipe leading to a trap into which cold water flows in order to condense the steam that may be discharged with that which is condensed. Because the pressure and temperature are even in the compartment, the vegetables cook evenly and thoroughly.

Various kinds of vegetables may be cooked at one time because the compartments are separate and can be controlled and operated separately without interfering with the other compartments in any way. While one compartment may be open the steam still remains turned on in all the others and the work of these is not impaired in the least. The vegetable steamer can also be used to heat canned fruits or vegetables in the can, or when removed from the can and placed in a kettle. It will prevent the burning of food, which so often occurs over a gas flame.

Potato Peeler

The potato peeler is a necessary adjunct to any kitchen. The amount of time saved over the old hand method is so great that this equipment will make up for its original cost in a very short time. It consists of a cylindrical shell about sixteen or eighteen inches in diameter, lined inside with a carborundum material about one inch thick.

The bottom is revolved by a small motor at a speed of approximately 400 revolutions a minute, while the shell remains stationary. This bottom movement causes the potatoes to be thrown against the outer shell and the centrifugal force holds them in place, causing them to be rotated at a lower speed against the sides of the peeler. In this manner the potatoes are peeled and all that remains is the removing of the eyes. A spray pipe on top supplies the water to the potatoes and also washes the refuse through the opening between the rotating disc and the shell. When the door is opened the potatoes are discharged automatically into a receptacle on the floor. Some potato peelers are made of cement but the operation is the same in every way.

Steam Table

The steam table plays an important part in a steam-operated kitchen, because it serves to keep the food hot after it is prepared and while it is being served. It consists of a sheet-metal cabinet with a water-tight compartment about fourteen inches deep on top, and shelf

space to keep the plates warm underneath. This compartment is filled with water. The top of the steam table has various holes into which fit the pans and pots holding the food. These pans and pots extend into the water about ten to twelve inches.

A steam coil supported by a one by one by one-eighth inch angle-iron is laid on the bottom of this compartment so that the water may be heated almost to the boiling point. This coil should not be less than one inch in diameter to provide the necessary heating surface for quick action. The inlet to this coil must be valved and the outlet connected to the warming coils below the shelf. The water connection to the compartment can be brought in from the top or side as is most convenient. If brought into the side, the connecting flange must be soldered to the side to prevent leakage.

Often no overflow is provided, claiming that it is not necessary. After the compartment is filled and the water shut off, it will not overflow. Let us remember, however, that we are dealing with the human element and the operator frequently forgets to shut off the water. The result is that the kitchen is flooded and perhaps there is considerable damage. A leaky valve on the water supply may fill the compartment during the night when no one is present, and cause still more damage. The safe way is to provide an overflow. This can be connected to the side or may be brought up through the bottom with a nipple extending upward to a point about one inch below the top. The overflow should be of ample size, not less than one and one-quarter inches, to take care of any emergencies which may arise. A steam table installed and connected as here described, gives excellent results.

A hood should be installed over this table to draw off any steam or odor that may be present, particularly the steam escaping around the pots and pans when too much steam is turned on the coil. The plate warming shelf underneath should be provided with a steam coil which receives its steam from the coil in the water compartment. The outlet from the shelf coil is connected to a steam trap in the same manner as described in the portion on the cereal cooker, and need not be repeated here. There are a great many different ways, more or less efficient, to connect the steam to steam tables. The writer has changed many steam connections which did not work satisfactorily, and has found that if they are connected as this article suggests, satisfactory results are obtained in all cases. In the selecting of the trap for the steam tables, about thirty per cent should be added to the heating surface of the coils when the trap capacity is figured, because the rate of condensation will be considerable while the water is cold.

The Dish-washer

This essential piece of equipment receives too little attention in most cases. A few words at least must be said about the proper connection to the dish-washer, which in this particular installation takes care of 3,000 dishes in one hour. No matter what type of dish-washer is selected, all must have hot and cold water connection.

In some dish-washers, and these are by far the most successful, there is also a steam connection. This connection is only three-eighths of an inch and is sufficient to clean the dishes and sterilize them properly, which is absolutely necessary from the sanitary standpoint. Hot and cold water connection of ample size, not less than three-fourths of an inch, should be brought to the machine, and at least a two-inch sewer connection, provided with a trap located in a convenient place to allow for easy cleaning in view of the fact that the refuse from the dishes will frequently plug up the trap when a careless operator does not find it necessary to remove all the food from the dishes before placing them in the washer.

Most dish-washers are hand-operated, that is, the dishes are placed upright in the basket and are then pushed by hand into the machine. While one basket is full of dishes which have been washed, the other basket may be loaded. Steam at forty pounds' pressure is sufficient for any dish-washer. The water should be kept as hot as possible to obtain clean dishes. In most cases the reason why dirty dishes come from the dish-washer is that the water is not hot enough. The water in the washing department should be 180 degrees F., and in the rinsing department 200 degrees or more.

Special baskets are used for cleaning silver. There are various compounds on the market intended to cut the grease and produce clean dishes. The writer has found that a compound consisting mostly of soda ash will fulfil this purpose. The stuffing box of the circulating pump must be packed with a good grade of packing. It is customary to use ordinary steam packing, which will cut out around the shaft in a little while. A floor drain under the machine is helpful in preventing a wet floor.

Milk Urn

A novel device is the new type of milk urn, which provides with each glass of milk the correct amount of cream. In the ordinary type of milk urn the cream floats on top of the milk, and no cream is served when the milk is drawn from the faucet connected to the bottom of the urn.

The new urn has a float attachment inside, with a small tube connected to the float and faucet. As soon as the faucet is opened the suction of the milk draws into the tube the right amount of cream from the top and mixes it with the milk before it leaves the faucet. In this way each glass of milk drawn receives its proper amount of cream.

General Equipment

This article would not be complete if we did not say a word about the gas-baking oven, the gas range, and the adjustment of the gas burners. For economical reasons, in most cities the gas pressure varies to such an extent that it is impossible to obtain the best results from the equipment mentioned, due to the fact that the air mixture can not be adjusted properly to give uniform results with a minimum supply of gas. The pres-

sure fluctuates greatly during the time when everybody uses gas at meal times.

A good gas regulator properly adjusted is of great help, and a saving of gas can be noted in nearly every case, because with a uniform gas pressure the air mixture on the burner can be so regulated that the flame will be supplied with the maximum of air possible, without causing the usual back-fire so often experienced when the pressure is low. A gas burner supplied with the proper amount of air will give a great deal more heat and will use less gas. This adjustment of gas can be made only if the gas pressure is kept even at all times. The gas consumption of the bake oven and range referred to, was materially reduced after the pressure regulator was installed and the air supply regulated.

The general layout of a modern kitchen should be such that storerooms can be provided close at hand for groceries and canned goods. All refrigerators should be cooled with brine coils, these coils to be located in the ice chambers and the brine to be circulated after it has been cooled in the power house by a centrifugal pump. Valves should be provided on the in and outlet side of the coil in each refrigerator so that the temperature of each unit may be controlled separately. No ice need be used except for ice packs for the patient, and this ice can be made between the coils in the power house brine cooling tanks.

It has been found that if this system is installed the refrigerating machine can be shut down after running six to eight hours, according to the outside temperature, and the brine circulated for the balance of the time in the refrigerators through the centrifugal pump. The saving in the electric current or steam, as the case may be, is considerable; also the wear and tear on the compressor is greatly reduced. The water used to cool the ammonia or C. O. 2 condenser coils, can be discharged into the house tank and used for flushing toilets, or in the laundry.

Let us for a moment look at a kitchen equipped as described, from the economical standpoint, to see if all the time we have expended here and in planning the installation, is really worth while. There is no doubt about it. In this kitchen meals are being served to 132 patients in twenty-five minutes by five girls. This will indicate what can be accomplished in a modern, steam-operated kitchen, properly arranged and properly connected to the steam supply, with ample consideration for the removal of condensed steam from the various steam-operated equipments.

Should the Fifty-Bed General Hospital Have Intern Service?

J. P. Dean, M.D., St. Mary's Hospital, Madison, Wis.

St. Mary's Hospital, which is now making additions to its present capacity of seventy beds, has the services of two interns and is among the smallest hospitals approved for internship by the Council on Medical Education and Hospitals, of the American Medical Association.

SHOULD the fifty-bed general hospital have intern service? The answer to this question can be made readily if we include in the answer many provisions. Hand in hand with the progress which has occurred in medical sciences during recent years, has been the progress in hospitals. And we may say that this progress is in its infancy. Because standing still means going backward, hospital service and intern service must keep pace with the progress in medicine.

When we look back not many years and picture the conditions in the hospitals, their size, their number, the equipment, the intern service, and make comparison with the present-day situation, we note many differences and many improvements.

What was the condition in the past?

In the larger cities we found hospitals of various sizes. In the cities of moderate size the presence of an adequate hospital was a rarity and in the smaller cities it was the exception. The education of the medical student was not as thorough nor as comprehensive as it is at present. Following graduation, a high percentage immediately launched into practise. The remainder sought internship in the hospitals, especially in the hospitals located in the large cities where teaching institutions were affiliated, because here were found the teachers and the leaders in the profession.

The Value of Direct Contact and Observation

Entering such a hospital the intern derived an inestimable benefit from his service, perhaps better than is obtained today from a practical and clinical standpoint. The proportion of patients to an intern was very high, sometimes 100 or even 200. The records kept were meager, the mechanical aids to diagnosis were few, and the intern's time was given wholly to direct contact, bedside care, and observation.

Great men were developed and great clinicians grew from this arrangement. Descriptions of diseases and diseased conditions were written years ago which to the present have never been improved upon. At times the modern physician is wont to look upon the physician of those days with a feeling of superiority. The present-day physician depends less on his own faculties and is aided more in diagnosis by ingenious mechanical equipment.

For example, the older Doctor Agnew was called in consultation. Entering the sick room he removed his silk hat, sat by the bedside and observed the patient, placed his ear to the cardiac region, and left the room. Outside he informed the family physician that the

patient was suffering from an aneurysm of the right coronary artery and would die. Autopsy proved him absolutely correct.

Such was the old clinician, developed by contact with the patient, the anatomical laboratory, and the post-mortem laboratory; developed without the x-ray, the cystoscope, the electro-cardiogram, and numerous other helps which today we consider indispensable.

The Required Minimum

Contrast the present-day hospital with the past and we find elaborately planned and equipped institutions with every modern appliance for help in diagnosis and treatment. As a rule the larger institutions have considerable financial support and are able to furnish more to the patient. Likewise, interns are more easily obtainable for these hospitals and are gathered into them in large numbers so that there is one intern to twenty or twenty-five patients.

Where formerly hospitals were found only in larger centers, in recent years there has been a tremendous growth in number until we find in practically every community of a few thousand people and upward, hospitals of various sizes, kinds, and qualities. At the same time a reform has occurred, having its birth in the medical profession, to improve and to raise the standards of our hospitals to a required minimum so that the patient and all concerned may benefit to the fullest extent.

Coincident with the increase in the number of hospitals throughout the country and with the endeavors to raise the standards, come the overhauling of our medical schools, the elimination of numerous inefficient institutions, and an increase in the educational requirements in the schools that survived. The number of graduates is considerably less at present than at the time when we had fewer hospitals.

The Fifty-Bed Hospital

With all of this we must admit that the fifty-bed hospital needs intern service and should have it, provided it can complete the education of the young man who has just graduated.

What are the disadvantages to an intern rounding out his education in a fifty-bed hospital?

Usually a unit of this type is not connected with an educational institution and little or no contact can be had with the leaders and teachers in medicine. As a rule these hospitals will be found in the smaller communities where the attending staff has not had the large experience of busier men and consequently lacks the advantages which come only with such experience. The variety and number of cases cannot possibly be as great as are found in large hospitals and larger cities.

Certain Obligations

A hospital should be able to give the interns serving it, a rotating service. To devote one's complete time and study to a certain specialty for a period, working under the direction of specialists, has advantages which cannot as well be obtained in a smaller hospital.

During the time of internship a certain amount of research work should be done. This need not be a big work, but enough to stimulate the interest of the intern and make a beginning. Research can be done more easily in larger institutions where a larger number of cases can be obtained and more material furnished, and where assistance from the heads of departments is available.

To offset these disadvantages we can say that an intern will derive only as much benefit from his service as he gives study and diligent attention to the patients under his care. It is in the man to make the most of his opportunities, and one may obtain as much from a fifty-bed institution as another will from a thousand-bed hospital.

In a smaller hospital fewer cases can be studied more thoroughly and as much benefit derived from them as a larger number. Usually in such a hospital the majority of patients are private cases. The intern has the advantage of coming in closer contact with them and learns more to act as the doctor should, acquiring that touch of dignity and kindness which sometimes means success in practise.

It is necessary for a hospital, to be recognized by the American College of Surgeons, to fulfil certain minimum requirements. To meet these requirements completely it is necessary to have intern service. A fifty-bed hospital should have intern service, provided the intern can obtain the same service he would obtain in a larger institution.

This means greater cooperation from the attending staff, to aid the intern in every possible manner by example of diligent study of the cases in the hospital. An indefatigable enthusiasm for progress should be shown by each and every doctor entering the hospital so that their devotion to their work can aid only as an inspiration to the intern to excel in this, the greatest of all professions.

When we recall the fact that the great Corrigan accomplished his large, important work in a hospital of six beds, we can realize that for the right man there are great possibilities in a hospital of fifty beds.

Will Lay Cornerstone in July. The cornerstone of the new St. Mary's Hospital at East St. Louis, Ill., will be laid on July first, Bishop H. J. Althoff, of Belleville, laying the cornerstone. A special program is being arranged for the occasion, to include musical entertainment, addresses by prominent citizens and other special speakers, and special numbers by the children of the city.

The new hospital will cost more than a million dollars and will be one of the finest in the country. It will be entirely fireproof in construction, and will contain approximately 200 additional hospital beds, recreation rooms, children's nurseries, and twelve well-furnished sunrooms for convalescent patients. The three-wing type of construction will be used, with four stories and a basement, all to be used for hospital purposes.

An enlargement of the present nursing staff is planned to supply the increased demands of the hospital, and plans have also been made to use the enlarged hospital institution as an intern hospital for graduate students of medicine.

Honor Woman. Miss Florence R. Sabin, physiologist at Johns Hopkins medical school at Baltimore, has been elected to life membership in the National Academy of Sciences. Miss Sabin who has done notable research work in blood cells, is the first woman chosen to membership in the 62 years of the academy's life.

The Education of the Nurse*

Sister M. Florence, R.N., Mercy Hospital, Baltimore, Md.

An occasion like the present is likely to hold out the insidious temptation to laud the progress of Catholic activities in general, and of the Catholic hospital in particular; a temptation which is rendered the more difficult of resistance because it has been inspired and fostered by the numerous congratulations from press and public which voice a widespread appreciation of the good work accomplished in our hospitals. All this commendation might persuade us to repose upon our laurels, but we must resist the thought and "forgetting the things that are behind," press forward, impelled by the American passion for progress, and still more by zeal to make our Catholic hospitals foremost in the field. We shall rather direct the scope of this paper to a more practical purpose, considering ways and means for justifying our right to the confidence placed in us as nurses and educators of nurses.

First we may ask, in what manner have our own American people of today elected to make manifest the appreciation for hospitals and nursing, which we are certain they cherish? They have done so by deeds rather than by words. They have shown their confidence in us by crowding our Catholic hospitals until at the present writing the bed capacity is found to be hopelessly inadequate and over-taxed. Succinctly, and with eloquence, the following figures will reveal the facts in the case. They are taken from HOSPITAL PROGRESS:

The Proof of Confidence

"The bed capacity of all the Sisters' general hospitals in the United States and Canada is more than half the bed capacity of all the hospitals conducted by those of other religious denominations and by lay organizations, as well as by states, cities, and counties. The demand is so great for Sisters in hospitals that twice the number of Sisters could well be used in the work now being done. More than 4,000,000 people pass through these general hospitals every year, 70,000 of the medical profession are on their staffs, and about 25,000 lay nurses are receiving instruction in the various nursing schools attached to the Sisters' hospitals, while between seven and eight hundred chaplains administer to the spiritual wants of the patients."

Evidence of the confidence reposed in our hospitals demands of us a return adequate in all particulars, since, as is pointed out in "America" for March 15th, 1924, "just as naturally our position becomes precarious and one fraught with added responsibility to the people. For, if it is true that we stand today in the sun of popular esteem, it is no less true that tomorrow the searchlight of standardizing agencies will be slowly but surely trained and focused upon us. In such a crisis obviously it is for us to continue to maintain our traditional position of honor and prestige. This, however, I venture to assert, can not be done unless we forthwith abandon our present principle that 'sufficient for the day is the excellence thereof.'"

A great statesman once said, "I know of no means of judging of the future except by the past." Applying this norm of practical experience, and disclaiming any preternatural gift of divination, we assert with confidence that even as the educational standards and consequent nursing efficiency of the past were not so high as those of today, so the standard of excellence today will not be so high as the standard of the impending future. The writing is even now upon the wall, and she who runs may read.

New Training School Standards

Should the rumor that presages the standardization of schools of nursing, materialize in the near future, it were well to remind ourselves of some possible results which might follow in the wake of the proposed tests. These are necessarily so exacting that only the best equipped schools may hope to survive their searching scrutiny. For those that fail, a nurse's career will hold out discouraging prospects. Such failure would probably disqualify the student for admission to the state board examinations.

It does not matter who set these standards. Our chief concern is that they exist, and we must meet them unless we wish to join the ranks of those to whom Father Moulinier referred at the 1924 Catholic Hospital Association Conference when he said, "Why must Catholics always trail, never lead? Is not our cause worthy of perfection? Do we hesitate to undertake for God's poor what seculars dare for worldly motives?"

More than ever before, schools of nursing are calling today for applicants sound of mind and body, upright in character, and noble of purpose. A young woman chooses our school for this or that special feature; it may be university affiliation, unusual laboratory facilities, instructors of recognized superiority. It may be for a more special training, or perhaps for the privilege of elective work. Certainly it is for some definite reason. To our inquiry, "Why did you come to our school?" we no longer receive the answer, "I don't know, except that it is a Catholic school." The ambitious young woman of today knows what she wants and will not be satisfied with counterfeit. It is well to consider, therefore, what is expected of us.

A survey of standard schools throughout the country proves that wonderful progress is being made in the field of nursing education. Such schools aim to achieve through personnel, equipment, and curriculum, a high level of educational attainment. The personnel of our leading schools comprises a superintendent and her assistant, and at least two full-time instructors qualified for their important position.

The equipment of the standard nursing school includes classrooms, library, lecture halls, chemical and diet laboratories, demonstration rooms, gymnasium, and outdoor recreation facilities. A daily schedule extending over eight hours is favored, and the leisure time so necessary for relaxation and study is scrupulously provided for.

Better Educational Facilities

Where it is possible, the school of nursing has become a department of the university to which its associated medical school is affiliated, thus offering the student nurse the advantages of well equipped laboratories, instructive clinics, and competent teachers. University affiliation, which to some of us now seems a dream far distant, impracticable, and even, I fear, undesirable, will in a short time be as much a matter of course among the best schools, as state registration is today. We of Maryland are exceptionally fortunate in regard to educational facilities, for our state university has just inaugurated a course in which graduates of standard schools of nursing may secure the degree of Bachelor of Science. This course will occupy the student for five years, two of which must be spent at the College of Arts and Sciences at College Park, and the other three at a standard hospital.

*Read before the first annual meeting of the Maryland Conference of the C. H. A., Baltimore, April 24, 1925.

Before entering upon a consideration of the curriculum, let us ask, what are the educational requirements for our schools of nursing? Much thought has been expended and much time consumed in the answer to this question. It is commonly agreed that a full high school course is necessary in order that a student reap a 100 per cent result from her professional subjects. Let us note the salient features of the curriculum. Its mastery may justly be regarded as a mental feat, even on the part of those who come to us equipped with an efficient high school education. Standard curricula have been arranged and adopted by nearly all schools. There seems but little difference in opinion now as to what should be included in the nurse's education. Variations do occur, however, as to the year in which certain subjects prove most advantageous.

Distribution of Studies

The preliminary course and first year include anatomy and physiology, bacteriology and hygiene, chemistry, nutrition, diet and cookery, with principles of nursing, presented in the form of lectures and demonstrations and practise under classroom supervision. Principles of nursing, in all schools, are continued throughout the first year. Too much stress cannot be placed upon this branch, for if the student be allowed to adopt wrong principles at the start, she will carry them through her entire nursing career.

Ethics and history of nursing cannot be introduced too early in the course and must continue throughout the entire period of three years. If we offered a more definitely planned course on the historical, ethical, and social basis of nursing from the standpoint of psychology, we should not fail to develop in our students a deeper appreciation of the nursing profession and a keener grasp of that nursing spirit of which we hear so much. Because of negligence in this matter, young nurses sometimes bring unfavorable criticism upon the profession, failing, as they evidently do, to realize that the primary cause behind all medical and nursing schools is the poignant need of the ill.

Practical nursing on the wards under close supervision is part of the daily routine, occupying from four to six hours. Supervision is imperative. The decided decrease in hours of hard work and the increase in classroom work is noted everywhere. There are schools of nursing offering as many as five hundred hours of theory in the preliminary course alone. This arrangement seems most logical because during that period in which the student is of little real value on the ward, she is devoting her time to theory.

The second or junior year studies should comprise medical nursing, surgical nursing, operating room technique, obstetrics, pediatrics, diet, and disease.

The aim of the third year schedule is to broaden the nurse's field of observation, to teach the relationship between mental and physical illness, and the application of general nursing principles to mental nursing. A thorough course in psychology, with an introductory review of the anatomy and physiology of the nervous system, introducing neurology and its associated conditions, makes evident to the student the reasons for the treatment to be used in each case.

In the second semester the professional problems which may confront the nurse after graduation are anticipated and met in a rational and effective way. The nurse is urged to show some initiative and elect a choice of future specialty. For this end she is allowed a greater round of more responsible charges toward the end of her scholastic term.

Opinions of Educators

Such is the outline of the three-year course, and it must be evident to the most superficial observer that the intelligent mastery of this curriculum presupposes a full and complete high school education as its basis. But some may contend that the number of high school graduates who will apply for admission into nursing schools will by no means reach the required quota. An answer to this objection may be found in the words of those familiar with the field.

Miss Agnes Keane Fraentzel, Secretary of the New Jersey State Board of Examiners of Nurses, says: "I greatly rejoice at this news of the increase in the number of young women entering schools of nursing, and frankly believe it is due in part to the fact that the old time fear of hard labor for three years has been removed from hospitals, but more especially to the fact that schools of nursing have become institutions of education."

Miss Blanch Pfefferkorn, Executive Secretary of the National League of Nursing Education, testifies that "Large numbers of applicants are applying and being admitted to schools of nursing, especially those schools which maintain high educational standards."

Miss Anna C. Jamme, Director of the Bureau of Registration of Nurses, San Francisco, says: "We find that young women applying to enter schools of nursing have high educational qualifications and seem inspired with a very definite purpose in taking up the career of nursing."

But are young women going to be attracted to our Catholic nursing schools in sufficient numbers to meet the present needs for service? Not until a radical bracing up has been effected. Our schools generally offer every reasonable inducement but one; that one is the most important of all, educational opportunity. While decent living conditions go without saying, they are secondary after all. Other things being equal, the hospital of the future which maintains a waiting list of applicants for its nursing school will be the one that offers the substance and not the shadow of a real education.

The Need for Educated Leaders

Catholic hospitals cannot hope to attain a position of eminence until opportunities for study and postgraduate courses are provided for the Sister instructors in the nursing schools and for the Sisters who supervise the various departments in the hospital. How are student nurses to acquire new viewpoints unless their teachers have them? And how are teachers to keep in line with all this new thought without reading and study and postgraduate courses from time to time? The idea that the teacher must always be a student, that continuous growth is a fundamental standard of the profession, is cited by Doctor Bagley as one of the axioms of the teacher's creed. We might well adopt it, not only for nurse teachers but for the heads of the different departments in the hospital, executive as well as professional.

In the nursing field, perhaps more than in any other, there is a great need for educated women—leaders, instructors, supervisors, technicians, and superintendents of hospitals and schools of nursing. Such women are found only where the best is to be obtained. Therefore, if we desire women of this type we must offer them the opportunities they seek.

That we must keep abreast with the medical profession cannot be denied. The last five years point with pride to the advanced educational requirements exacted of schools of medicine and pharmacy, and surely these schools experience no dearth of students. Should we be less progressive than they? Can women whose formal education comprehends merely the curriculum of our grammar grades be the intelligent co-workers of college men? Can we hope to maintain our social and professional standing with doctors if we show no desire to advance when medicine is bounding ahead?

A Source of Moral Strength

And what of the spiritual side of the nurse's education? The average nurse of today comes to us still in her teens, immature, emotional, inexperienced. "She dreams of the joys of an ideal service to humanity, she sees herself a ministering angel." From these roseate dreams she must necessarily awaken to the stern realities of a very hard and humdrum routine of daily duties. Where shall she find strength for the combat? Where but in the persuasive whisperings that rise out of a memory filled by moral and spiritual training with antidotes for every sorrowful and discouraging phase of this laborious career which she has elected.

The spiritual helps given the Catholic nurse must naturally find place in her curriculum. From daily Mass, from daily banqueting on the Bread of Angels, will come her power of resistance. Added to these chief sources of spiritual life, will be her own devotion to and trust in her who is the "Salus infirmorum," and her rosary will be to the nurse a talisman. In natural sequence must come our Lady's Sodality, binding together in close-knit bonds the members who meet to honor her. All these devotional exercises should be made attractive to the nurse for whose help they are intended, and never should she be led to regard the duties of her religion as added burdens.

Finally, since the type of nurse in great measure determines the character of the hospital, we should endeavor to make the graduate of our Catholic schools an ideal nurse, loyal to her God, to her school, and to herself, "for the loyal nurse is the ideal nurse, and the ideal nurse must be a joy to the angels in heaven. 'A little lower than the angels,' God created man, and far above her fellows in the race of life, is the loyal, God-fearing, devoted nurse. For, if she acts upon proper motives, she has ever for a patient, Him who is the consolation of all men."

The Patient's Boook

Rev. E. F. Garesché, S. J.

(Excerpts Continued from the April Issue)

Thoughts About God

To begin with, if we wish to love God we must know Him and realize something of His infinite lovableness. We cannot see God with our mortal eyes nor touch Him with our bodily senses. Only reason and faith tell us of His existence and His lovableness.

The reason that we cannot see or touch God is our own imperfection, not any fault of His infinite being. God is everywhere, within us and without us. In Him we live and move and have our being. He sustains us in all our actions, and without his constant help we at once drop back into the nothingness from which we came. But the reason why we cannot see nor touch Him is that our poor bodily senses are not able to receive any impressions of a pure spirit, and God is the infinite spirit, of whom this material universe is the creation, faintly mirroring His endless perfections.

Our eyes can respond only to the waves of light which enter them, and these waves of light are reflected only by material substances. Now, as God is a pure spirit He can not be seen, because light is not affected by His infinite substance. He is superior to all material conditions and the eye can give no evidence concerning Him. So, too, our touch registers only the form, the hardness, or the speed of material things. God is not material but a pure spirit, and so we can not feel nor touch Him and our senses can render no testimony concerning Him.

The Truth of God's Existence

But all this is no reason whatsoever for doubting that God exists. We might as well doubt the existence of the human soul, which likewise we can neither see nor touch but which is manifested to us by its activities. The soul has no color, shape, or form, because it is a spirit. Yet union with the soul makes the body alive, and the difference between the body with a soul and without it, is the difference between the vital, sentient, active human being and a cold, lifeless corpse.

So, also, God is made manifest to us by the effects of His power and goodness on the created universe. No well balanced and normal mind can see the stars of a summer night and remember the great teachings of astronomy without feeling his heart expand with awe and wonder at the greatness of the Creator of all these huge orbs which give brilliance to the midnight sky. Immeasurably vast, roaming about the dizzy spaces of the sky, each one of these huge worlds and suns describes most faithfully its appointed orbit, swinging with the utmost precision, guided by the almighty power of God. How worthy to be loved is that unseen yet most manifest Creator whose praises are sung by the flaming choirs of the stars across the face of a summer night! How admirable and how much to be loved is the Eternal Spirit whose goodness has made Him wish to prepare the immemorial stars to shadow forth to us His love and power!

The Beauties of Earth

Consider again the bright and various beauties of this world in which we live. Though the earth is a place of exile for our fallen humanity, a place of trial and probation, where we sojourn but a little while before departing for heaven, still God has adorned it with wonderful majesty and beauty as a dim foretaste of the glory and joy with which He will fill the courts of heaven.

Consider the splendor of the seasons, the bright beauty of spring when the earth is strewn with flowers and the young leaves on the trees twinkle like gems in the flooding sunshine. Recall the lavish plenty of summer when the fruit is maturing in countless orchards, when the fields are teeming with produce, and the flocks and herds in the meadows multiply for the service of man. Consider the rich abundance of autumn, the golden and generous autumn, when the hand of God seems stretched over the world, blessing it with productiveness, scattering colorful abundance into every valley and on every hillside.

Reflect on the white sleep of winter when the earth is resting for another springtime. It is the power of God which keeps the life in every sapling, which gives to every living thing its refuge from the winter's cold, so that when the death-like pallor of winter is melted and the steaming earth trembles in the sun of spring, every tiny insect comes forth and wanders down the breezes, saved in its fragile nature from the killing frost, by the fostering hand of God.

Man's Immortal Soul

Consider again your own human body and soul with all their extraordinary powers. It is God who planned you and made you and who keeps you in existence despite the many forces which work for your destruction. What is more marvelous than the body of man, except only his immortal soul? You are made in the image and likeness of God. Your body, with its complicated balance of

powers, is His handiwork. In the full tide of health you hardly realize, perhaps, how marvelously you are made and how many delicate adjustments go to complete the full perfection of your life and health.

But when sickness lays you low, then you begin to appreciate how marvelous and intricate is your body. Any one of a thousand processes which goes wrong may reduce you to weakness and helplessness. Yet your body has also the power of regenerating and renewing its own health and vigor. Even from a bed of sickness you may rise up again to stronger and more vigorous health than ever before, and all this only faintly shadows forth the power and the lovableness of God.

Then reflect on your immortal soul, on that wonderful spirit which, united with your body, gives it strength, health, sensation, the power of motion, life itself. The mysterious union of your body and soul is the work of God, who created your soul out of nothing and joined it to your body in the first moment when you began to be. This soul is the principle of your health and growth. It is the reason of your life, but besides, it has an existence of its own which will continue forever, even after death, even during the ages which may elapse between the time your body dissolves into dust and the moment when it rises again to be reunited with the soul on the last day.

In the Image of God

This immortal spirit of yours has intelligence, memory, and free will, faculties which make it indeed an image of the nature of God. By means of its intelligence it can comprehend truth and can reason from one thing to another, thus developing its knowledge in a wonderful way. By means of memory it can recall the past, can profit by the experiences of others which it has heard and retained. By means of free will the soul can deliberately choose between good and evil, can perfect itself and make itself constantly more like God by aspiring to imitate His goodness more and more.

Now this body and soul are both the gifts of God. Eloquently they proclaim the goodness and lovableness, the power and wisdom of the Giver. To love God we need only consider ourselves and ask ourselves how good, how perfect, and worthy to be loved is He who has planned and created everything we have and everything we are.

Then, too, the whole course of our lives should make manifest to us the lovableness of God. It is He who sends the air unto our nostrils, who gives food to our lips, and drink, who provides the clothing we wear upon our bodies. It is He who has supplied to us all those who comfort and help us. Our parents and friends, our well-wishers and helpers, all those who are kind to us and assist us, they also are the work of God's hand. He made them and He sustains them in being, so that they may help and befriend us.

Thus if we use our reason we may see about us everywhere proofs of the existence of God and of His infinite lovableness. If the creatures on the face of this earth are beautiful and lovable, as so many of them are, then their beauty is only a faint reflection of the boundless beauty of God; their lovableness is but a faint spark of the great sun of God's infinite being. He is the source and fountain from which their charms must flow. He Himself therefore is endlessly more beautiful and lovable than they.

The Lovableness of Christ

But if reason teaches us so much about the lovableness of God, faith is still more eloquent. We know by faith that the only begotten Son of God so loved men as to come down from heaven and become one of our race, taking a body and a soul like ours, and resembling us in all things, as St. Paul says, sin only excepted. Read the gospels and you will find on every page evidences of the lovableness of Christ. He is the most amiable, the most beautiful, the most entrancing to human hearts, of all the children of Adam. The multitudes flock after Him even into the desert, forgetting their hunger and their thirst in their eagerness to hear His words and to feast their eyes upon His countenance, full at once of dignity and sweetness. He summons the apostles and at a word they leave their friends and their homes to follow Him, one from his fishing net, another from where he sits taking custom, all inspired by the same personal devotion which this God-made-Man inspired in human hearts.

Even today, nearly two thousand years after these scenes of Christ's mortal life, an ever increasing multitude of men and women love Him with a devotion greater than that which they give to any other being. For Him they give up willingly everything they possess. They leave their homes, as did the apostles at two words, sweet music, "Follow Me." The Sisters whom you see in a hospital have thus placed the love of Christ above all other love, and many, many, thousands of Catholic Sisters throughout our land and in all the lands of the earth, are thus following Christ in complete poverty, purity, and obedience. How lovable then must that God be, who is thus beloved.

Infinite Love

But is is when we look upon Christ dying on the cross that we begin best to understand His infinite lovableness. This is the eternal Son of God, equal by His nature, with God the Father and the Holy Spirit, in all eternity. He is infinitely happy by His own right and infinitely powerful. Yet of His own free will He has come down from heaven to be our Savior and in the excess of His infinite love He has chosen thus to be sacrificed for us on the cross. It was not needful that He should so suffer and die, but He does this of His own free will in order to win our love. Consider His agonized countenance, in which the greatness of His suffering is shadowed. Look upon His pierced hands and feet and see His side, opened by the lance, where the last drops of His blood flow forth.

It should be easy indeed to love a Savior who has first shown such self-sacrificing and self-immolating love for us. "Greater love than this no man hath, that a man lay down his life for his friend." If we bring vividly before us the endless love of our Savior it will not be hard to love Him purely and sincerely and for His own sake in return.

We should therefore make an act of the pure love of God on many occasions throughout the day. When we are in grief or pain such an act will be a consolation for us and will make our suffering meritorious. When we are calm and at peace an act of pure love will form our best thanksgiving to God. When some great benefit comes to us we should receive it with pure love, which is the greatest gratitude. When we wish to pray for some benefit, an act of pure love of God is the surest means of obtaining it.

NOTE: The Patient's Book from which these chapters are taken is being published by the Catholic Hospital Association as a service to the Catholic Hospitals. An announcement of the book will be found opposite page 67a.

Affiliated with Head Sodality. The nurses' sodality of Creighton Memorial, St. Joseph's Hospital, Omaha, Nebr., under the primary title, Our Lady, Help of Christians, secondary title, St. Agnes, has recently received its diploma of affiliation with the head sodality in Rome. At present there are forty members and also a large class of candidates who will be received on the feast of Our Lady Help of Christians. The sodality is under the zealous direction of Reverend F. X. Reilly, S. J.

Hospital Progress

EDITORIAL EXECUTIVE COMMITTEE:
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Edward A. Fitzpatrick, Milwaukee, Wis.
Rev. Edw. F. Garesché, St. Louis, Mo.
William C. Bruce, Milwaukee, Wis.

WHY IS IT?

The writer recently had occasion to be in a southern city. While there he visited some of the hospitals. The first was a large, non-sectarian hospital and the head of one of the departments spent a long time with me, showing me about the hospital, especially the new addition with it excellent out-patient department. He introduced me to various members of the staff and extended every courtesy to me.

That afternoon I visited a large Sisters' hospital in the same city, which I greatly wished to see because it was just opening a new addition which doubled its capacity. I introduced myself as a friend of Father Moulinier and one of the editorial writers of HOSPITAL PROGRESS. I was informed by the Sister at the desk that I came at a bad hour; there was nobody she knew of who could show me around and if I would, I might just go about by myself and see anything I wanted to. This was a large as well as an indefinite order. I asked her if she could assure me that I would not be thrown from a third story window or hustled out as an intruder. She assured me I would not. Of course it was impossible for me to make any inspection of the hospital, although I did find a courteous lay nurse who took me to the dietitian's department, where I met a very bright and charming young woman who was perfectly willing to answer questions and show me her department.

On my way north I had an almost similar experience in another city in a Sisters' hospital which had just been opened and is the teaching center of a medical school conducted by the Jesuits. I introduced myself as I had to the previous Sister. She assured me she was very glad to see me, and said if I would sit in the parlor for a few moments she would get some one who could show me over the whole hospital.

I had just forty-five minutes to spend in the hospital. After I had spent thirty of those in the parlor, a young Sister came in and said she understood I wished to see the hospital. I said I *had* wished very much to see it but I had been given so much time to change my mind that I really thought I didn't care to go about, especially since I had only fifteen minutes left. She was so charming and apologetic, however, that I did spend the few minutes remaining, to good advantage in the record room, but of course could see little or none of the hospital.

I was really sorry that she came in because I had made up my mind to spend a few minutes with the Sister who was still at the desk within about thirty feet of where she had put me half an hour before, to tell her how much I appreciated the courtesy shown a friend of Father Moulinier and a writer for HOSPITAL PROGRESS. Did I think she knew me as one who has said unpleasant things in the editorial pages of HOSPITAL PROGRESS, I could conceive of her having personal reason for not being courteous; but I am quite sure she did not know me as "E. E."

I relate the foregoing incidents without any attempt to draw a moral. The moral should be self-evident.—E. E.

OUR GOITER PROBLEM

Some readers may object that this is not the place to discuss goiter. In explanation to those conscientious critics who would hold that this magazine should treat only of matters pertaining directly to hospital control, administration, or efficiency, we might add that viewed from that standpoint alone, a review of the manner in which each hospital handles its goiter patients might easily reflect much concerning the efficiency of its record room, the harmony existing between its clinical and pathological departments, the finesse with which anaesthesia is controlled, not to say the skill shown by its surgeons in choosing patients for operation and carrying out the surgical details.

Of course it must be admitted that, like the tariff, the problem of goiter is likely to be ultimately "a local issue," because not all regions are equally goitrous, nor is the situation presented in widely varying districts by any means the same. Thus it is seen that the most divergent methods are at times advocated, in which, among other things, it would appear fairly clear that the observers are using a common terminology for conditions which vary under very wide limits.

The type of goiter exhibiting toxic signs, in the mid-west area about the Great Lakes, certainly does not usually react well to roentgen-ray exposure, despite what some may intimate it has done much nearer the sea-coast.

Just now, when so much had been hoped for from goiter prophylaxis, with the more or less general use of iodin in public drinking supplies or in various iodized salts, comes some immediate and pressing evidence that this indiscriminate intake of iodin, even in small amounts, by all classes and all ages, is possibly ill-advised.

In the meantime, however, each hospital—particularly those in goitrous zones—has a distinct opportunity to fulfil its possibilities of assisting in this broad, loose type of general research, and can carry out a very useful public health function by carefully observing the material passing through its institution. The advantages and limitations of basal metabolic readings are no longer subject to debate; every hospital attempting any conscientious goiter work or study, must of course have well standardized equipment for this most useful procedure.

It seems to some, working in hospitals where the goiter problem has long been before them, that since this more or less widespread and general use of iodin, as

mentioned, there is forthcoming a somewhat different type of goiter toxicity, with persistently high basal metabolic readings, than those previously encountered and readily classified either as toxic adenoma or the true, outspoken, thyroid hyperplasia of Graves' disease.

It may be offered that the other well known factors productive of toxicity in goiter, viz., psychic shock and strain, and current infection, are presently responsible for the increase in thyroid toxicity in individuals who do not have adenoma or in whom there was nothing previously but the remains of adolescent or colloid struma. Iodin starvation and availability are so dynamic a factor in instituting goiter and at least temporarily controlling toxic phenomena arising from perverted thyroid tissue, that it seems quite unwise to tamper with what must be a delicate status of susceptibility in a wide range of individuals in their especial environment.

In other words, while it seems entirely justifiable, and advisable indeed, to give iodin in small amounts to all children between the ages of 6 and 12, it is becoming equally obvious that there may be grave danger in indiscriminately handing it out to those over 18 with or without goiter.

Each hospital has a chance to perform a very useful function in studying carefully the goiter it sees; in holding up and retaining accuracy in metabolic studies; finally, in carefully correlating the clinical data exhibited, with the pathological tissue studied at operation.

—E. L. T.

ARE YOU COMING?

The Catholic Hospital Association of the United States and Canada takes special pleasure in extending again to all its members and friends, a pressing invitation to attend its tenth annual series of conferences at Spring Bank, Okauchee, Wisconsin, June 22nd to 27th, inclusive. The Association feels deservedly proud of its continent-wide achievements for the betterment of hospitals and higher standards of service from the hospital personnel during the last decade. This is due unquestionably to the persevering spirit of appreciative cooperation magnanimously evidenced by the hospitals of the United States and Canada, in carrying out at all costs in every department of the hospital, those methods and lines of treatment which insure more scientific and surer care of the patient.

The Association begs to broadcast that it has left nothing undone to make this coming series of conferences duly practical from all angles, for goodness, truth, and beauty to an eminent degree in the hospital. The general outline of the program has been thoughtfully wrought out in its minute details. The papers, all bearing upon eminent religious, scientific, and artistic development, functioning, and efficiency in the hospital, have been assigned to respective specialists from all parts of the country. The reports of standing and new committees will bring about some round table discussions which will elucidate theories and perhaps solve a prospective controversy for hospital eminence.

The usual large number of exhibitors, with their choice hospital wares, will be present. Ample time will be given after each session of the conferences to allow the Sisters and other attendants to make a pleasant, instructive, and business visit to the exhibit hall.

The call for reservations has been increasingly large in the last few weeks, and the Association rightfully expects representatives from every state in the Union and from every province in Canada. Nothing will be spared to make this stay of a few days on the shores of Lake Oconomowoc most home-like, restful, harmonious, and instructive to hospital people.

Let us all earnestly say a prayer for the success of the 1925 conference, to insure eminence in religion, science, and art in the hospital. Are you coming?

—N. J. G.

HOSPITAL DIETS

Our president, Rev. Father C. B. Moulinier, after visiting many hospitals and traveling widely, points out very accurately that hospitals are falling down rather routinely in the fields of dietetics and mental and nervous diseases. As to the latter, a discussion must be postponed until some later time; regarding the former, it would be a good thing for every well organized hospital staff to devote one or two meetings exclusively to an understanding of an ideal approach to the problem of dietetics, and to an understanding of the facilities already provided by the hospital.

One may visit many institutions and find an array of physical therapy or complicated hydrotherapy installations, all neglected and pushed to one side solely because the staff either hasn't studied the indications for their use or cultivated a clientele which finds these adjuvants pleasing and satisfactory. In the same order, many a staff member might be considerably surprised to find that the hospital in which he practises has a well trained dietitian, entirely competent to carry out his minutest directions, but quite incapable of conforming to his poorly understood and vague directions.

For example, in a hospital the name of which need not be mentioned, a very well informed staff member wrote on the entrance slip for a patient, "Feed this patient twenty-five hundred grams of five per cent vegetables!" This would make at least one bushel basketful, and often more, of various kinds of fodder, and would at least keep the patient fletcherizing sufficiently to burn up so much energy that more calories might well be needed.

While it is well for every staff contemplating such a study of diets, to begin on diabetes, it should not be forgotten that the same caloric method of feeding can be applied with great satisfaction to obesity or to underweight. Where patients can be grouped and taught and induced to enter into the spirit of the plan, great things may be accomplished.

Much food is wasted in hospitals because standard servings or meals are brought to people totally unable to eat them. It is not, however, from the standpoint of saving supplies that this study of dietetics should be instituted; rather should it be our effort to remove the just criticism that our American hospitals are presently backward in an understanding and observance of reasonable dietetic control.—*E. L. T.*

Preliminary Program of the Tenth Annual Conference of the C. H. A.

Spring Bank, Okauchee, Wisconsin,
Monday, June 22nd, to Saturday, June 27th, Inclusive.

Monday, June 22—

2:00 P. M. President's Address, "Types, Policies, and Ideals of Hospitals," Rev. C. B. Moulinier, S. J.

2:30 P. M. "The International Catholic Guild of Nurses, Its Needs, Organization, and Purposes," Rev. E. F. Gareschè, S. J.

3:00 P. M. General Report on Activities of all Catholic Hospital Association Committees their Past, Present, and Future Work, General Acting Chairman, Rev. N. J. Gilbert.

3:30 P. M. Round Table Discussion of Preceding Papers, led by Mothers Superior, Chairmen of Committees, Superintendents of Nurses, Clergy, and Doctors.

4:00 P. M. Appointment of Special Committees.
Adjournment. Visit to Exhibits.

Tuesday, June 23—

10:00 A. M. Paper, "Trained Hospital Personnel."
Round Table Discussion:
Executives.
Heads of Departments.
Information Desk.
Bookkeeper.
Dietitians.
Engineer.
Head Cook.
Bursar.
Technicians.
Doctors.
Chaplains.
Housekeeper.

11:00 A. M. Committee Reports:
1. Committee on General Education of Hospital Sisters.
2. Committee on Superintendents of Training Schools.
3. Committee on Anaesthetists.
4. Committee on Operating Room Supervisors.

12:00 M. Adjournment. Visit to Exhibits.

Tuesday, June 23—

2:00 P. M. Paper, "Character in the Hospital."
Round Table Discussion:
1. Unity and strength of authority throughout the hospital.
2. Genuine, sincere, honest, and fearless conferences attended by members of all departments.
3. Complete, carefully kept, and accessible records.
4. The obligations of secrecy in regard to private facts pertaining to patient's history and record.
5. Fairness, clearness, and decisiveness in the exercise of hospital control — economical, scientific, and religious.

3:30 P. M. Committee Reports:
1. Committee on Record Keepers or Historians.
2. Committee on Executives and Administrative Officers.
3. Committee on Chaplains.
4. Committee on Supervisors of Floors.

4:00 P. M. Adjournment. Visit to Exhibits.

Wednesday, June 24—

10:00 A. M. Paper, "The Soul of Service."
Round Table Discussion:
Formal, dead routine a menace to all—initiative and intelligent system the antidote.
Some hazards to patients growing out of lack of skill and kindliness, delay, neglect, ignorance, rudeness.
Culture in mind and manner of whole personnel. Spirit of alert helpfulness to all.
Art touches in whole service—food and trays, corridors, rooms, solaria (color, form, symmetry).

11:00 A. M. Committee Reports:
1. Committee on Hospital Social Service.
2. Committee on Pediatrics.
3. Committee on Obstetrics.
4. Committee on Dietetics.

12:00 M. Adjournment. Visit to Exhibits.
END OF FIRST CONFERENCE.

SECOND CONFERENCE

Thursday, June 25—

10:00 A. M. Paper, "Christian Culture in the Whole Hospital.
Round Table Discussion:
Spiritual and corporal works of mercy. Primary and secondary obligations growing out of right to life and its well-being possessed by every human creature.
Consideration of the rights and needs of others, the mark of the real Christian.
Knowledge of Christ's religion and manifestation of its refining virtues of meekness, gentleness, and humble kindliness are essentials in the life and activities of every Catholic hospital.

11:00 A. M. Committee Reports:
1. Committee on Kitchen Supervisors.
2. Committee on Telephone Service.
3. Committee on Information Service.
4. Committee on Office Service.

12:00 M. Adjournment. Visit to Exhibits.

Thursday, June 25—

2:00 P. M. Paper, "The Call of God."
Round Table Discussion:
Why so few vocations from pupil nurses and from graduate nurses?
What can and should be done to increase the number?
How many hospitals have sodalities and yearly retreats for nurses?
What can and should chaplains do to increase piety, devotion, and consequently vocations in the hospital?
Proper, convenient, and abundant reading matter.

3:00 P. M. Committee Reports:
1. Committee on Vocations.
2. Committee on Hospital Library.
3. Committee on Sodalities and Retreats.

4:00 P. M. Adjournment. Visit to Exhibits.

Friday, June 26—

10:00 A. M. Paper, "Christliness in the Hospital."
Round Table Discussion:
Are meekness, gentleness, kindliness, virtues of too rare and exalted a character to expect in the doctor and interns while they are functioning throughout the hospital?
Can the examples of Sisters and nurses in the daily practice of these virtues bring about an atmosphere of Christliness in the hospital which doctors, interns, and patients will appreciate and imitate?
Is the spirit of self-denial and willing sacrifice so marked a characteristic of Catholic hospitals that every patient and every worker is elevated in soul and transformed to a better life through its inspiring influence?

11:00 A. M. Committee Reports:
Committee on Religious Virtues and Practice of Christian Perfection in the Hospital.

12:00 M. Adjournment. Visit to Exhibits.

Friday, June 26—

2:00 P. M. Paper, "The Great Hospital."
(What Makes the Hospital Great?)
Round Table Discussion:
How much has size (number of beds) to do with the greatness of a hospital?
What is the value of physical plant, equipment, location, and surroundings compared with the internal spirit—ability, knowledge, skill, harmony, and active co-operation, together with all the effective Christian virtues?
Should every Sisters' hospital be a great hospital and reach **eminence?**
Are they all great? If not, why not?
Is the achievement of **eminence** in all undertakings a religious obligation?
Should all Sisters' hospitals contribute their share to the advancement of medical knowledge by up-to-date and conscientious care of the sick, and by research?

3:00 P. M. Committee Reports:
1. Committee on Pharmacy.
2. Committee on Radiology.
3. Committee on Hospital Research and Autopsies.

4:00 P. M. Adjournment. Visit to Exhibits.

Saturday, June 27—

10:00 A. M. Paper, "The Hospital With and Without a Future."
Round Table Discussion:
Types of Hospitals:
1. **Stagnant** — stand-pat, listless, without a future.
2. **Commercial**—doctors' workshop; hotel for sick.
3. **Minimal**—doing least possible for patients; drifting.
4. **Mediocre**—doing just enough to get by; self-satisfied, ignorant, and visionless.
5. **Progressive**—hospitals with a future; intelligent, trained, ambitious, and conscientious personnel.
6. **Eminent**—hospital with a high, urging, divine discontent.

Program for Second Annual Guild Conference

The second annual retreat and conference of the International Catholic Guild of Nurses will be held this year from May 31st to June 6th, inclusive, at the headquarters of the Guild, Spring Bank, Okauchee, Wisconsin, on the banks of Oconomowoc Lake.

The following program has been prepared for the retreat and conference:

Retreat

May 31st
8:00 P. M. First instruction of the retreat.

June 1st, 2nd, and 3rd
Continuation of retreat, closing noon of June 3rd.

Afternoon of June 3rd
Period of recreation and sociability for the nurses.

Second Annual Conference

June 4th

10:00 A. M. Address by Rev. C. B. Moulinier, S. J., President of Catholic Hospital Association.
Address by Rev. E. F. Garesché, S. J., General Spiritual Director of International Catholic Guild of Nurses.
Address by Miss Kathryn McGovern, President of International Catholic Guild of Nurses.
Reading of minutes of preceding meeting.
Reports of committees.
Unfinished business.
New business.
Election of officers for the ensuing year.
Addresses of new and retiring officers.
Appointment of committees.
Announcement of program for ensuing year.

June 5th

10:00 A. M. Paper: "Opportunities in Nursing Education," Miss Evelyn Wood, Central Council of Nursing Education, Chicago.
Paper: "Opportunities of the Nurse as an Instructor in the Training School," Sister Domitilla, St. Mary's Hospital, Rochester, Minn.
Paper: "The Nurse's Opportunities in Higher Education," Major E. A. Fitzpatrick, Dean, Graduate School, Marquette University, Milwaukee.
Paper: "Opportunities of the Nurse as a Social Worker," Rev. Francis P. Le Buffe, S. J., Fordham University, School of Sociology, New York, N. Y.
Round table and discussion of preceding papers.

2:00 P. M. Paper: "Opportunities of the Navy Nurse," Miss J. Beatrice Bowman, Department of Navy, Washington, D. C.
Paper: "Opportunities of the Industrial Nurse," Miss Mabel Boyd, U. S. Rubber Company, Chicago.
Paper: "Postgraduate Courses and Scholarships," Miss M. Blanche Adkinson, Instructor, St. Mary's Hospital, Minneapolis, Minn.
Paper: "Opportunities of the Nurse Working among the Deaf and Dumb," Rev. Stephen Klopfer, St. John's Institute, St. Francis, Wis.
Round table and discussion of preceding papers.

June 6th

8:00 P. M. Illustrated lecture: "Opportunities of the Dental Nurse, of the Dental Hygienist, and of the Dental Assistant," M. N. Federspiel, D.D. S., M. D., Milwaukee.

June 6th

10:00 A. M. Paper: "Nursing Opportunities," Miss Anna C. Jamme, California State Board of Health, Sacramento, Calif.
Paper: "Opportunities of the Army Nurse," Major Julia Stimson, Dean of the Army School of Nursing, Washington, D. C.

2:00 P. M. Paper: "Spiritual Opportunities of the Catholic Nurse," Rev. John P. Boland, Buffalo, N. Y.
Round table and discussion of preceding papers.

2:00 P. M. Paper: "Opportunities in Psychiatric Nursing," Miss Rose Bigler, Chief Nurse, Peoria State Hospital, Peoria, Ill.
Paper: "Opportunities of the Nurse as a Bacteriologist," Miss Margaret Flynn, Bacteriologist, St. Joseph's Hospital, Chicago.
Round table and discussion of preceding papers.
Opening of question box. Answers to ethical and other questions proposed by the nurses during the conference.

HOSPITAL CONFERENCE ELECTION

At a meeting of the American Conference on Hospital Service in Chicago on March 11th, the following officers and trustees were elected:

Honorary President—Dr. Frank Billings.
President—Dr. S. S. Goldwater.
First Vice-president—Dr. Ralph B. Seem.
Second Vice-president—Miss Adda Eldredge.
Treasurer—Dr. Harry E. Mock.
The new trustees elected are:
Dr. A. C. Bachmeyer (reelected).
Dr. John M. Dodson (reelected).
Miss Ada Belle McCleery.
New appontments on the Library Commttee are:
Dr. William H. Walsh.
Major Edward A. Fitzpatrick.

SECTIONAL CONFERENCES
of Catholic Hospital Association of The United States and Canada

MARYLAND-WASHINGTON, D. C., CONFERENCE HOLDS FIRST ANNUAL MEETING

A new and important addition to the groups of state conferences in the Catholic Hospital Association comes in the organization of the Maryland Conference, including also the hospitals of Washington, D. C.

The first annual meeting of this body was successfully held April 24th at the Catholic Center in Baltimore, attended by seventy Sisters representing every Catholic hospital and many of the Catholic high schools of the archdiocese.

His Grace, the Most Reverend Michael J. Curley, D.D., Archbishop of Baltimore, was a special guest and in his address to the conference cited as examples of commendable hospital influence, the work of St. Leo's Hospital in Greensboro, N. C., and Mercy Hospital in Asheville.

"The finest source of Catholic influence in Greensboro, a city of forty thousand people and 350 Catholics, is not the church or the priest but the Sisters of Charity who are in charge of that hospital," His Grace said. "They are doing work no priest could do. They are pulling up the roots of bigotry. Out of the hundred patients in their hospital, eight are Catholic and ninety-two non-Catholic. These Sisters are giving a splendid example of the charity of Christ, and the people of Greensboro are enamored of their work. They are fulfilling the mission of the Catholic hospital." Before concluding his remarks His Grace expressed the hope that the need for a Catholic home for incurables and a Catholic home for aged women would soon be fulfilled.

The opening address of the conference was delivered by the Reverend Joseph L. Curran of the Shrine of the Sacred Heart, Mount Washington. Father Curran, Archdiocesan Director of Hospitals, explained the purpose of the Catholic Hospital Association and declared that "next to the religious life itself there is no vocation of higher calling than the vocation to the nursing profession. The lives of nurses must show forth brilliantly the principles of love of God and love of their fellow men," he said

An interesting report on the year's work made by the president of the conference, Sister M. Clare of St. Agnes' Hospital in Baltimore, showed that 27,310 patients were cared for in the course of the year by the hospitals of the conference, and that 55,416 received treatment in the out-patient departments. Sisters actively engaged in this work number 182, and 347 young women are receiving their professional training in these schools of nursing.

Enlightening papers were presented by Sister M. Donata, St. Joseph's Hospital, Baltimore, "Some Practical Reflections and Suggestions on the Necessity, Construction and Equipment of a Nurses' Home"; Sister M. Florence, Mercy Hospital, Baltimore, on "The Education of Nurses"*; and Sister M. Rodriguez of Georgetown University Hospital, Washington, D. C., on "The Higher Education of Nurses."

Among those taking part in the discussions were Sister Anna, St. Agnes' Hospital, Baltimore; Sister M. Dona, Bon Secours Hospital, Baltimore; and Sister M. Berchmans, Providence Hospital, Washington, D. C.

The election of officers was postponed until the early part of September, when it is planned to make arrangements for the next annual conference, to which two or three days will very likely be devoted.

Present officers are:

Presidet—Sister Domitilla, St. Mary's Hospital, Baltimore.

Vice-president—Sister M. Thomasina, Mercy Hospital, Baltimore.

Secretary—Sister M. Flavia, Providence Hospital, Washington, D. C.

Among the hospital members of the Maryland-Washington, D. C., Conference, are: Mercy, St. Joseph's, St. Agnes' and Bon Secours Hospitals in Baltimore; Providence and Georgetown University Hospitals in Washington, D. C.; and the Allegany Hospital, Cumberland, Maryland.

*Appearing in this issue.

MINNESOTA-NORTH DAKOTA HOSPITAL WORKERS MEET IN ST. JOSEPH

April 14th, 15th, and 16th the Minnesota-North Dakota States Conference of the Catholic Hospital Association was held at St. Benedict College in St. Joseph, Minnesota, with representatives present from the hospitals of both states.

At the business meeting new conference officers were selected as follows:

President—Ven. Sister Domitilla, St. Mary's Hospital, Rochester, Minn.

First Vice-president—Mother Leo, St. Mary's Hospital, Minneapolis, Minn.

Second Vice-president—Sister Bernard, St. Ansgar's Hospital, Moorhead, Minn.

Third Vice-president—Sister Casilda, Loretta Hospital, New Ulm, Minn.

Secretary-treasurer—Sister Paul, St. Mary's Hospital, Rochester, Minn.

Executive Board

Sister Boniface, St. Alexius Hospital, Bismarck, North Dakota.

Mother Grace Aurelia, St. Joseph's Hospital, St. Paul, Minn.

Mother Salome, Trinity Hospital, Jamestown, No. Dak.

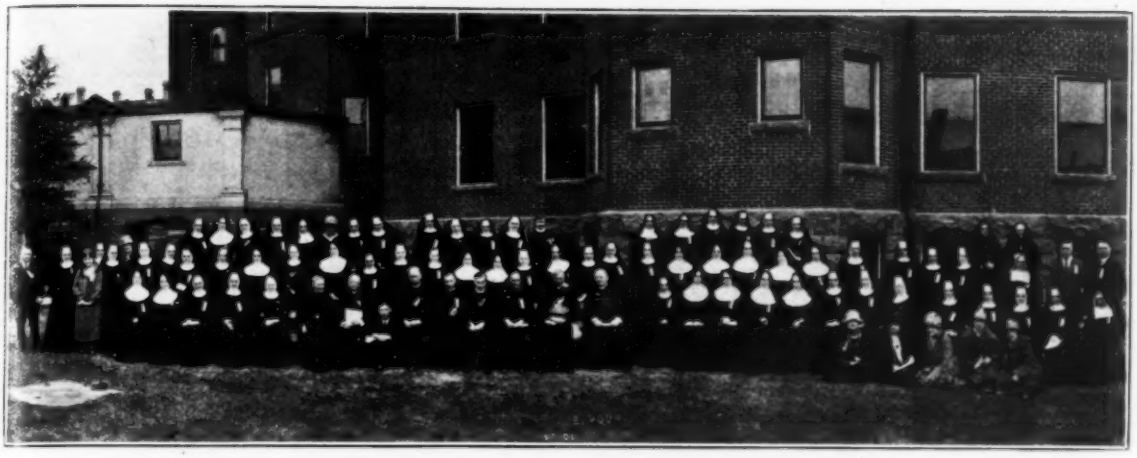
Sister Julitta, St. Raphael's Hospital, St. Cloud, Minn.

Sister M. Julitta, O. S. B., and Sister Christopher, both of St. Raphael's Hospital, St. Cloud, Minn., are the retiring president and secretary, respectively.

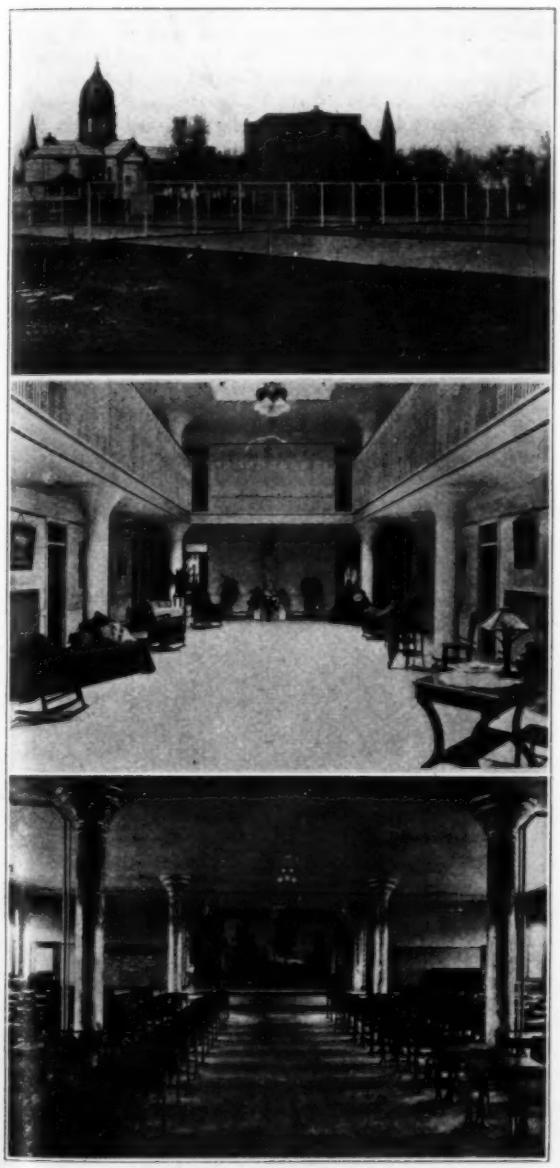
On the first morning solemn high mass was celebrated at St. Benedict College with a sermon by Rt. Rev. Joseph Busch, D.D., Bishop of St. Cloud, and the opening address was made by Rev. C. B. Moulinier, S. J., president of the C. H. A., followed by a paper, "Training School Problems,"* by Sister M. Stella, superintendent of nurses, St. Mary's Hospital, Duluth, Minn.

In the afternoon papers were read by Miss Mary Gladwin, Director of Nursing Education, St. Paul, Minn., "What a School of Nursing Means to the Hospital"; Dr. W. C. Rutherford, St. Paul, Minn., "Record Keeping in Detail"; Sister Emerama, St. Raphael's Hospital, St. Cloud, Minn., "The Relation of the Superintendent of the Hospital to the Superintendent of

*Appearing in this issue.



MINNESOTA-NORTH DAKOTA STATES CONFERENCE OF THE C. H. A., APRIL 14, 15, AND 16, 1925, AT ST. BENEDICT'S COLLEGE AND ACADEMY, ST. JOSEPH, MINN.



TOP: TENNIS COURTS; CENTER: ROTUNDA: BOTTOM: ASSEMBLY HALL. ST. BENEDICT'S COLLEGE AND ACADEMY, ST. JOSEPH, MINN.

Nurses"; Dr. Fred Stangl, pathologist of St. Raphael's Hospital, St. Cloud, Minn., "Importance of Cooperative Work in all the Departments in Insulin Treatments." Following the last paper there was a lecture on the subject of "Insulin," by a representative of the Eli Lilly Company.

Tuesday evening there was a musical entertainment for the delegates.

Wednesday morning's program consisted of several papers, "The Great Need of Ample and Sufficient Help in the Hospital," Rev. Edward Mahowald, diocesan director of hospitals, St. Cloud, Minn.; "Duties of the Floor Supervisor," Sister Aquinas, St. Mary's Hospital, Minneapolis; "Little Things that are Big Things in Hospital Management," Sister M. Boniface, St. Alexius Hospital, Bismarck, No. Dak.; "Favorable Impressions on the Reception and Discharge of Patients," Sister Eustace, Fargo, No. Dak.; "High Ideals in Nursing," Rev. Joseph Varley, chaplain, St. Raphael's Hospital, St. Cloud. These papers were discussed by the conference.

In the afternoon there were a question box, reports of officers and committees, the election of new officers, and an executive committee meeting, followed by dinner.

A three-act play was presented in the evening for the entertainment of the guests.

Thursday morning the conference delegates were taken on a sight-seeing tour to St. John's University, the St. Cloud Orphanage, and the St. Cloud State Reformatory. Following luncheon, the meeting adjourned.

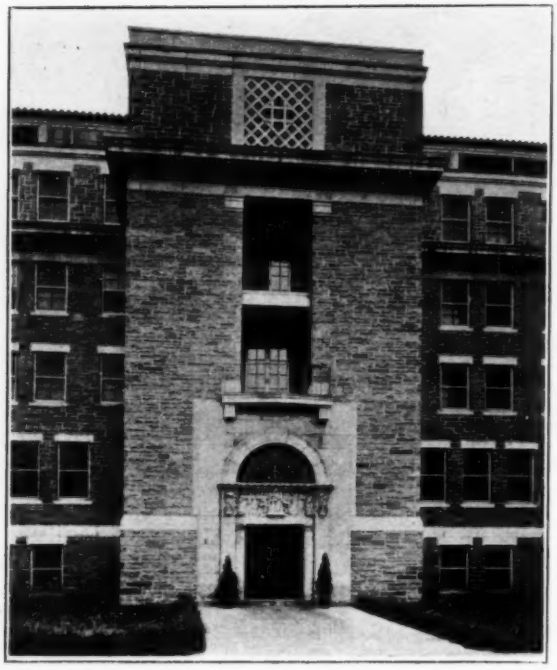
PENNSYLVANIA CONFERENCE HOLDS FOURTH ANNUAL MEETING

The Pennsylvania Conference of the Catholic Hospital Association of the United States and Canada, met in St. Agnes' Hospital, Philadelphia, on Monday and Tuesday, April 13th and 14th, for its fourth annual convention.

The proceedings were marked by constructive strides in the particular fields to which the Association has dedicated itself. The discussions, both formal and informal, together with round table sessions, brought together some of the greatest authorities in the state on medicine, surgery, hospital work and management. Representatives of the various Catholic hospitals of the state attended.

Cardinal Dougherty Welcomes Conference

The convention was ushered in at a solemn high mass (coram Cardinali) celebrated in the chapel of the hospital at 8:30 o'clock. His Eminence, the Cardinal, who presided and welcomed the delegates, was attended by the Right Rev. Msgr. James Nash, rector of the Church of the Epiphany, and the Rev. John J. Walsh, rector of St. Monica's Church, as chaplains.



ENTRANCE OF THE NURSES' HOME, ST. AGNES HOSPITAL, PHILADELPHIA, PA.

The Rev. John E. McCann, rector of St. Thomas Aquinas' Church, and chaplain at the hospital, was the celebrant of the solemn mass. The Rev. Edward L. Gatens was deacon and the Rev. Charles T. Dinan sub-deacon. The Rev. Gerald P. O'Hara, D.D., secretary to His Eminence, was master of ceremonies. The Very Rev. Albert G. Brown, S.J., president of St. Joseph's College, was present in the sanctuary.

After the gospel of the mass had been sung, His Eminence extended a welcome to the visiting members of the Association, praised the self-sacrificing efforts of the religious in their works of charity and religion, and asked the blessing of God on their work and the light of the Holy Ghost to make fruitful the 1925 convention.

After the mass, the Association convened in the assembly room of the nurses' home. Seventy Sisters were present from the following hospitals:

St. Agnes', Misericordia, St. Mary's, St. Joseph's and St. Vincent's, Philadelphia; Sacred Heart, Allentown; Mercy, DuBois; Mercy, Scranton; Mercy, Wilkes-Barre; Mercy, Johnstown; New Castle, New Castle; Providence, Beaver Falls; St. Joseph's, Lancaster; St. Vincent's, Erie; Mercy, St. Francis, St. John's, Rosalia, and Pittsburgh, Pittsburgh.

A cordial address of welcome was delivered by Monsignor Nash, who represented His Eminence at the conferences.

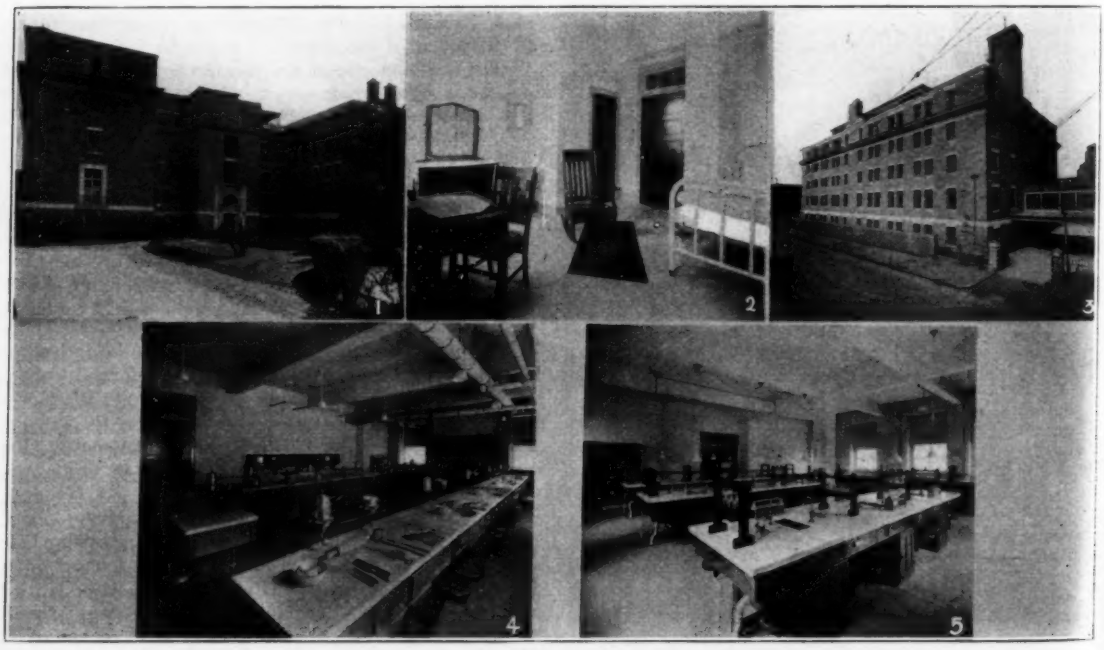
Discuss Practical Subjects

The following program of discussions, mostly of interest to the special problems and phases of hospital work and those engaged in hospitalization, was presented:

"Hospitality in the Hospital," Dr. F. X. Jones, Philadelphia; "Correlation between Theory and Practice in Nurse Teaching," Sister M. Regina, Mercy Hospital, Wilkes-Barre; "Economy in the Hospital," Sister M. de Lourdes, R. N., Misericordia Hospital, Philadelphia; "Medical Organization and Control in Catholic Centers," Dr. D. J. McCarthy, Philadelphia; "Legislation," Miss Margaret Dunlop, R. N., of the Pennsylvania State Board of Examiners, Philadelphia; "The Life of the Graduate outside the Hospital," Sister M. Ireneaus, Beaver Falls; "Round Table," Sister M. Geraldine, R. N., Lancaster.

Dr. Anna Dengel, medical missionary in charge of the hospital at Rawal-Pindi, India, who is visiting this country in behalf of hospitals for women and children in the land that St. Francis Xavier evangelized, was present and delivered a brief address. The subject of foreign medical missions was also discussed by the Rev. Stephen Sweeney, C. P., representing the Medical Mission Board of the Catholic Hospital Association of the United States and Canada.

Of interest to members was a special surgical clinic held at the Misericordia Hospital on Tuesday morning with all delegates present.



NURSES' HOME, ST. AGNES HOSPITAL, PHILADELPHIA, PA.
1. Front Exterior View; 2. Bed-room; 3. Side Exterior View; 4. Dietetic Laboratory; 5. Chemical Laboratory.

New Officers

At the close of the meeting the following officers were elected for the ensuing year of the Association:

President, Sister M. Ireneaus, Providence Hospital, Beaver Falls; first vice-president, Sister M. Rose, Mercy Hospital, Pittsburgh; second vice-president, Mother M. Edmunda, Misericordia Hospital, Philadelphia; third vice-president, Sister M. Thomasine, St. Francis Hospital, Pittsburgh; secretary-treasurer, Sister M. Rita, Pittsburgh Hospital, Pittsburgh; executive board, Sister M. Regina, Mercy Hospital, Wilkes-Barre; Sister M. Raphael, Mercy Hospital, Johnstown; Sister M. Bertrand, St. Mary's Hospital, Philadelphia, and Sister M. Laurentine, St. Francis Hospital, Pittsburgh.

Resolutions

The following resolutions were submitted by Sister M. Regina of Wilkes-Barre, and Sister M. Raphael of Johnstown, the resolutions committee:

"Be it resolved that the Pennsylvania Conference of the Catholic Hospital Association extend to His Eminence, D. Cardinal Dougherty, the sincere thanks of the Association for the great courtesy and kindness shown by gracing the convention with his presence, and assure him of their appreciation of his words of welcome and encouragement.

"Be it also resolved that the thanks of the Association be tendered the Rev. Mother and the Sisters of St. Francis, to the organist and choir of the Convent of our Lady of the Angels, who furnished the music for the holy mass, to Sister M. Georgina and her co-workers at St. Agnes' Hospital, and to Mother M. Edmunda, and the Sisters of the Misericordia Hospital, for the entertainment provided and the hospitality shown each and every Sister delegate.

"To all who participated in the program, as also those who planned it, the Association owes a debt of gratitude, and hereby tenders its thanks. Likewise to the press and its representatives, whose services are hereby acknowledged.

"Be it resolved that a copy of these resolutions be spread upon the minutes, and copies sent to all those to whom the Association is indebted."

Sister M. Laurentine, St. Francis Hospital, Pittsburgh, is the retiring president, and Sister M. Mechtilde, Mercy Hospital, Pittsburgh, the retiring secretary-treasurer.

ILLINOIS HOSPITAL ASSOCIATION MEETS

The Hospital Association of the state of Illinois convened May 1st and 2nd in the Hotel LaSalle and the assembly room roof-garden of the Ravenswood Hospital.

The opening day a round table discussion was conducted by Dr. Paul W. Wipperman, superintendent of the Decatur and Macon County Hospital, Decatur. Such subjects as case records, organization of boards of trustees, patients' complaints on service, National Hospital Day, the handling of supplies, legal aspects of record keeping, the stimulation of community interest, superintendents and hospital publications, charges for distinct services, the hospital superintendent and meetings of trustees and medical staff, and the hospital in the promotion of community health education were discussed.

The round table conference on May 2nd at the Ravenswood Hospital was conducted by Ada Belle McCleery, superintendent, Evanston Hospital, Evanston. This conference considered methods of attracting the best type of young womanhood to the nursing profession, arrangements for under-graduate nurses, holidays and sick leave for under-graduates, affiliation of the smaller nursing school with the larger hospital, phases of commencement as a community event, the problem of special nurses antagonistic to authorities of their own hospital, the nurse and doctors' orders, essentials of a nurse's clinical and bedside record, problems relating to candidates for probation, the feasibility of nursing schools in connection with all hospitals, the advantages and responsibilities of a school of nursing committee, the nurses' library, teaching facilities in the small school of nursing, training in tuberculosis and infectious disease nursing, and the matter of uniforms.

Dr. M. T. MacEachern, Chicago, Director of Hospital Activities of the American College of Surgeons, was chairman of the local committee on arrangements.

HIERARCHY COMMENT ON WORK OF C. H. A.

Reverend C. B. Moulinier, S. J., President of the Catholic Hospital Association, has received several expressions of congratulations from the heirarchy in connection with the tenth anniversary of the Association and the fifth anniversary of HOSPITAL PROGRESS.

Rt. Rev. Paul P. Rhode, D.D., Bishop of Green Bay, Wis., writes under date of April 28th:

"The tenth anniversary in the existence of the Catholic Hospital Association, calls for our heartiest congratulations on the remarkable success which this organization has, under your presidency, achieved.

"The ideals which it has set for itself and the methods it has adopted for their realization, have ever commanded our sincere admiration.

"Being within our fold the chief exponent and promoter of the scientific charity embodied in hospital effort, it is entitled to the gratitude of the entire membership of the church in this country.

"I take keen pleasure in extending to you and to the Catholic Hospital Association, expression of my best wishes for a prosperous future.

"May God continue to shower His blessings upon it."

The following is from Rt. Rev. Edward P. Allen, D.D., Bishop of Mobile, Ala.:

"I thank you sincerely for the May number of HOSPITAL PROGRESS which has just come to hand. The Catholic Hospital Association, of which you are the honored president, deserves our highest commendation because of the good work it has accomplished during the ten years of its existence.

"We have today seven large hospitals in the diocese of Mobile, and these institutions have been doing noble work in the cause of humanity and at the same time making the church known and respected by our separated brethren, who otherwise would know nothing of Catholicity. For this reason anything which will help to make these institutions more efficient has my cordial approval.

"I wish you every blessing in your labors."

From the Rt. Rev. Daniel J. Gercke, D.D., Bishop of Tucson, Ariz., Father Moulinier has the following, dated May 3rd:

"I have very happy recollections of the pleasant visit from you when I was rector of the Cathedral in Philadelphia, and I have always admired you for the zeal and activity you have manifested in the work of the Catholic Hospital Association. I take this opportunity of congratulating you upon the Association's tenth anniversary. I assure you of my deepest interest and approval, and beg God's blessing on the great work of the Association."

And from the Bishop of St. Cloud, Minn., the Rt. Rev. Joseph F. Busch, D.D., the following, written April 30th:

"Please accept my sincere thanks for the kindness you had in sending me the May issue of HOSPITAL PROGRESS, which marks the fifth anniversary of the magazine and the tenth of the Catholic Hospital Association.

"You certainly have much reason to feel encouraged over the success of these, your very meritorious undertakings for the standardization and development of the work of our Sisters' hospitals, which, as you say, you have

tried in every possible way to make worthy of the name Catholic.

"It is particularly this effort on your part which should be deeply appreciated by all concerned, for it represents the crux of the whole hospital question as far as the church is concerned, and certainly none is, or can be, more concerned than the church.

"I therefore sincerely pray God to bless these, your personal efforts, as also the progress of the work of our hospitals according to your ideals and wise counsels."

Also under date of April 30th, the Rt. Rev. Hugh Boyle, Bishop of Pittsburgh, writes:

"On the occasion of the fifth anniversary of the establishment of the magazine HOSPITAL PROGRESS, and of the tenth anniversary of the organization of the Catholic Hospital Association of the United States and Canada, I beg to offer my sincere congratulations upon the great good which they have accomplished. The contact among Catholic hospitals has been of enormous value in improving the technique of hospital work, and in putting valuable discoveries in individual hospitals into a common treasury from which the whole group of hospitals may enrich itself. The publication, HOSPITAL PROGRESS, has been an invaluable agent in the dissemination of information regarding the improvement of the technical work in hospital management and administration."

EASTER AT NEW YORK'S MISERICORDIA HOSPITAL

Bertha M. de Lourdes Stanford, R.N.

Most of us know what an unusually busy life the hospital religious leads. From morning until night she finds herself fully occupied with the various duties of the department to which she has been assigned, for it is she more than any one else, who must carry the responsibility. And with all these other occupations, she must not fail to keep her rule, nor neglect her private devotions, no matter how weary she finds herself when evening comes. Although it would seem, then, that there could be nothing extra attempted by these faithful and untiring Sisters, a brief illustration may show the contrary to be true, as the writer has but recently observed.

If any of my readers during Holy Week could have stepped into the main foyer of the Misericordia Hospital, which is under the direction of the Sisters of Misericorde in the great metropolis of New York City, they might have noticed an unusual air of activity, quiet but constant, especially among the Sisters themselves, apart from the usual routine of hospital work.

Although Lent is the season of solemnity, particularly as it approaches the end, still these good Sisters, amid their usual Lenten devotions, were preparing early for the approaching Eastertide. They saw in it their opportunity to give to all the patients of the hospital as beautiful and as memorable an Easter day as possible.

As early as the Wednesday of Holy Week, looking out from my office into the main corridor, I saw gifts of beautiful flowers arriving—tokens, most of them, of appreciation and regard for these Sisters, from doctors, nurses, and grateful patients. As I read the sentiments expressed with the remembrances, I could not help but realize, in a very real way, what the work of these Sisters of Misericorde was meaning in and about New York City to hundreds of people whom they had befriended and served in some special time of need, both Catholics and non-Catholics alike, as evidenced by some of the floral gifts sent by non-Catholics with the request that they be placed upon the chapel altar with all the rest. Needless to say, the Sisters placed them there with fervent prayers. Who can tell what the final result may be through the example and faithfulness of these and many other hospital religious who are laboring thus for the extension of Christ's kingdom?

TYPICAL EASTER TRAY AT THE MISERICORDIA HOSPITAL, NEW YORK, N. Y.

Although the picture of the chapel as it appeared in the April issue of HOSPITAL PROGRESS, does not adequately describe its transformation on the joyous occasion of Easter, it may carry its own message, and make more widely known this active and much appreciated Catholic charity in the heart of New York City, which invites any of the magazine's readers who come to New York, to call and become better acquainted with the Sisters of Misericorde.

There is another side to these Easter preparations which impressed me deeply, especially because this was my first Easter in a Catholic hospital for a number of years. The Sisters, knowing that a good many of the patients were too ill to leave their beds on Easter day, and would therefore miss the beautiful sight of the chapel with all its appropriate decorations, planned in another way to bring some of the Easter cheer and joy to these sick rooms.

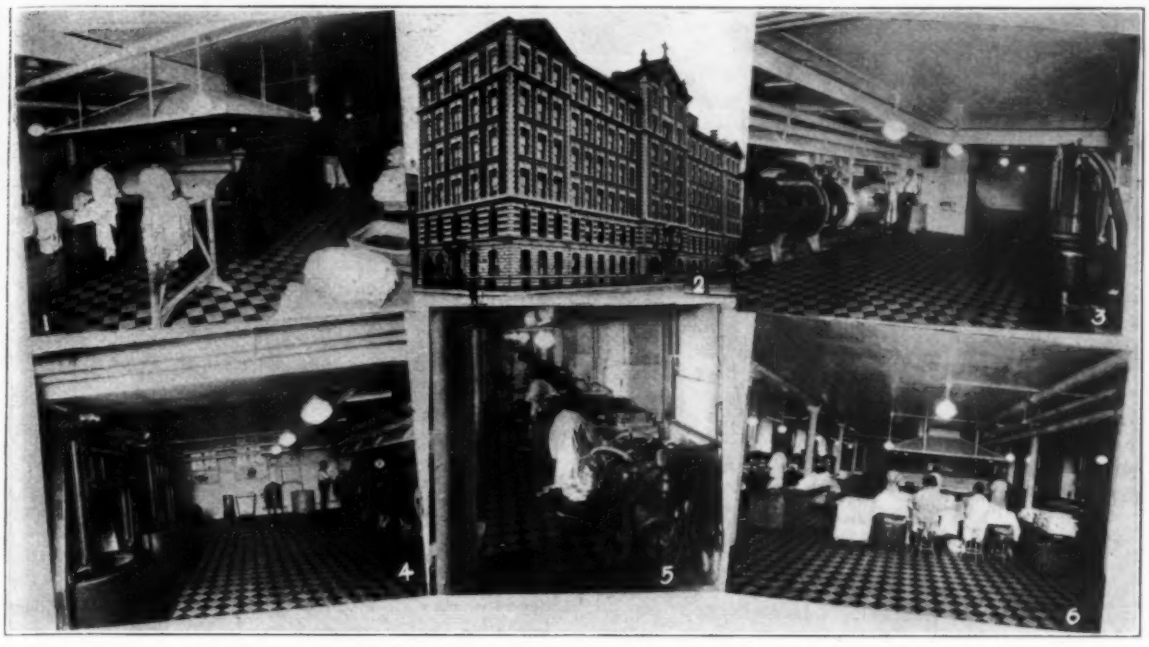
Some days previous, therefore, a number of these busy Sisters were seen during recreation hours and in spare moments, working with cardboard and fancy colored papers, and surrounded by a quantity of Easter eggs, large and small, bunnies, and chocolate rabbits. And finally more than 300 beautiful Easter baskets were ready, trimmed and filled, to be placed on the trays of all the patients as a little message of loving thought. I would not forget to add that the nurses also were sharers in this thought of the Sisters.

My own dainty Easter basket is still a silent reminder to me of the significance of the lives of such devoted religious, with their unceasing ministry of love. As for these, and all other hospital religious, in the midst of their constant toil, which is hard at best, and the many burdens which such service imposes upon them, surely their hearts must need often to receive Divine encouragement. And can there be any greater than the assurance which our dear Lord has already given to such unselfish devotion?

An example like this at Misericordia helps all of us to strive more earnestly to carry the beautiful spirit of Easter with us throughout the year in our work, wherever we may be, that our lives may be ever a blessing to others, and that we, in return, may truly come to know, more and more, the real joy of service.

A young lady having asked a surgeon why woman was made from the rib of a man in preference to any other bone, he gave the following gallant answer:

"She was not taken from the head lest she would rule over him; nor from the feet, lest he should trample upon her; but she was taken from his side, that she might be his equal; from under his arm that he might protect her; from near his heart that he might cherish and love her."



LAUNDRY INSTALLATIONS AT ST. VINCENT'S HOSPITAL, NEW YORK, N. Y.
(2. EXTERIOR VIEW OF HOSPITAL.)

Fundamentals of Laundry Arrangement and Equipment

By "Laundry Expert"

The frequency with which questions pertaining to laundering and the laundry department have occurred at hospital conventions and have appeared in hospital publications, shows the importance attached to this branch of hospital administration.

Perhaps the lack of general information pertaining to this department is greater than in any other. The object of this article is to furnish some information on the laundry and laundry methods, which may prove of general interest to all concerned. Let us approach the subject through questions and answers, as follows:

1. What is the best location for the laundry?

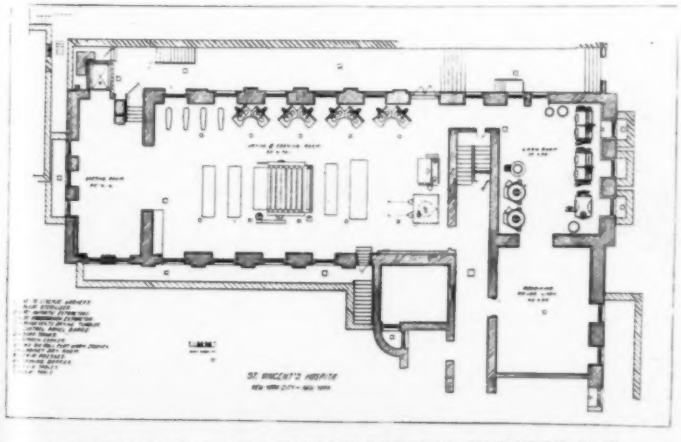
This is largely dependent on local conditions, but it is advisable to have the laundry in a building separate from the main hospital, preferably in close proximity to the power plant and boiler. If this arrangement is inadvisable, the next best place is in the basement of the main building, provided sufficient light and ventilation are available.

2. How should a laundry be lighted and ventilated?

This is a most important feature in the planning of a laundry department, and should be carefully studied. Large windows as well as adequate electric lights must be provided. A large ventilating fan should be placed near the ceiling, operated by an electric motor. In addition, it is advisable to construct ventilating hoods and ducts over the washing and ironing machines, to remove the surplus moist air and steam from the laundry. These ventilating hoods and ducts have proven most satisfactory and have greatly improved working conditions.

3. What is the best shape for a laundry room?

The best laundry room is rectangular or square. It is well to have it so built that but very few, if any columns are used. The receiving room for soiled linens should be separate from the main laundry room and from the room for infected linens. The clean linen room should be located at a convenient point, where linens can be stored direct from the laundry.



LAUNDRY PLAN AT ST. VINCENT'S HOSPITAL, NEW YORK, N. Y.

Laundry Precepts

Some other precepts to be considered in connection with the construction of a laundry are these:

1. Have an entrance of sufficient size, so that machinery can be brought in without being taken apart.

2. Have steam lines and return lines of sufficient size to permit use of hot, dry steam.

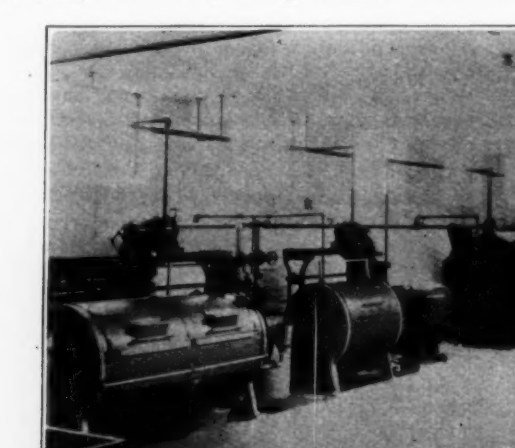
3. Use sufficient steam traps or an adequate return line to insure dry steam.

4. Locate the steam-heated machinery in as close proximity to the boiler and power plant as possible.

5. Have a sufficient supply of soft, hot water for all laundry needs.

In case electric heat is used in place of steam heat, these restrictions do not have to be observed. In fact, the machinery can be located wherever it is most convenient and without regard to the power plant. The leading manufacturers of laundry machinery are now in a position to furnish certain machines electrically heated as well as electrically driven. Much greater convenience results, since it is only necessary to turn on electric switch in order to heat the machinery. The machines have thermostatic control which insures even temperature.

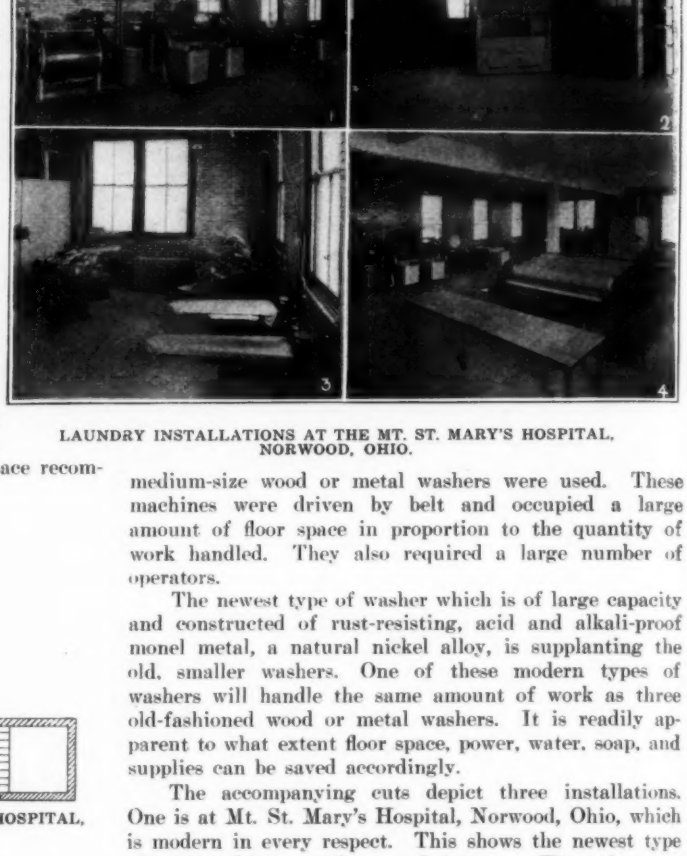
The ideal size for the laundry in hospitals and institutions of various sizes is a matter to be determined by the engineer making the layout. The minimum sizes of actual floor space recommended for the laundry are as follows:



LAUNDRY PLAN FOR THE MILWAUKEE COUNTY HOSPITAL, WAUWATOSA, WIS.

1. 50-bed hospital—20 x 52 feet.
2. 100-bed hospital—35 x 42 feet.
3. 200-bed hospital—42 x 45 feet.
4. 300-bed hospital—46 x 52 feet.
5. 500-bed hospital—50 x 64 feet.

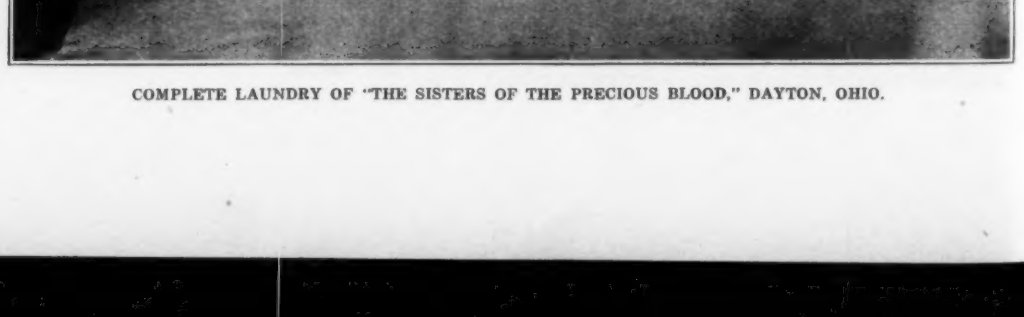
The requirements for hospital laundries have changed considerably. Previously a large number of small and medium-size wood or metal washers were used. These machines were driven by belt and occupied a large amount of floor space in proportion to the quantity of work handled. They also required a large number of operators.



LAUNDRY INSTALLATIONS AT THE MT. ST. MARY'S HOSPITAL, NORWOOD, OHIO.

The newest type of washer which is of large capacity and constructed of rust-resisting, acid and alkali-proof monel metal, a natural nickel alloy, is supplanting the old, smaller washers. One of these modern types of washers will handle the same amount of work as three old-fashioned wood or metal washers. It is readily apparent to what extent floor space, power, water, soap, and supplies can be saved accordingly.

The accompanying cuts depict three installations. One is at Mt. St. Mary's Hospital, Norwood, Ohio, which is modern in every respect. This shows the newest type of motor driven washers and ironers. The other cut depicts the washroom and the ironing room of St. Vincent's Hospital, New York City. This installation features the monel metal Cascade washer, individually motor-driven, and the Prim press, which has virtually supplanted hand ironing. Two floor plans show typical laundry layouts. These are an improvement on the



COMPLETE LAUNDRY OF "THE SISTERS OF THE PRECIOUS BLOOD," DAYTON, OHIO.

old style hospital washroom. The cut opposite shows the modern laundry of the Sisters of the Precious Blood, Dayton, Ohio, featuring the newest type of washers, a four-roll, extra flat work ironer and presses, all individually motor-driven. Such comparisons could be extended indefinitely, but these will perhaps show sufficiently well how much progress laundry machinery and laundry practice has made during the past few years.

CLINICAL PATHOLOGY

Review and Digest of International Medical Literature Concerning Laboratory Technique, Laboratory Diagnostic Methods, Laboratory Apparatus etc. Edited and directed by

EDWARD L. MILOSLAVICH, M. D.
Professor of Pathology and Bacteriology, Marquette University, Milwaukee, Wis.

CALCIUM DETERMINATION IN THE BLOOD SERUM

Johann Grill, M. D.

In the last few years the determination of calcium in the blood has shown a great diagnostic importance. The recent studies of calcium metabolism in cases of rachitis, osteomalacia, tetany, etc., attracted much clinical interest for the quantitative examination of the blood for calcium.

Practically all the newer methods for these determinations use permanganate solutions for titration. The solutions of potassium permanganate are, however, in diluted concentrations somewhat unstable and for that reason for each test they are freshly prepared and tested, thus requiring much time. The new method, as described by F. Lebermann, tries to eliminate the titration with potassium permanganate and makes the test more practical.

Principle of the Method

The underlying principle of the method is to precipitate the calcium of the blood serum as calcium oxalate and to convert it into calcium carbonate. The calcium carbonate is dissolved in excess hydrochloric acid and the amount of acid required for bringing the carbonate into solution is determined by titration. For the reaction, the following solutions are necessary:

(a) Saturated solution of ammonium oxalate.
(b) Saturated solution of sodium carbonate.
(c) N/50 solution of hydrochloric acid.
(d) N/100 solution of sodium hydroxid.

The fluid (blood serum) to be examined is pipetted into a centrifuge tube and a definite amount of ammonium oxalate is added; thereby a precipitate of calcium oxalate is formed. After standing for at least one-half hour, the fluid is centrifuged at medium speed for twenty to thirty minutes and afterward the supernatant fluid is carefully pipetted off with the aid of capillary pipettes. To the remaining sediment distilled water is added and again centrifuged for ten minutes. Again the supernatant fluid is drawn off and the same washing procedure is repeated two to three times.

The precipitate of calcium oxalate, washed in this way, is converted into calcium carbonate. The centrifuge tubes containing the sediment are placed in a sand bath and kept in the hot air apparatus at 200-250° C. for one-half to three-quarters of an hour. At that temperature most of the calcium oxalate evolves carbon monoxid ($CaC_2O_4 — CO = CaCO_3$).

After this procedure, in order to convert every trace of calcium oxalate into calcium carbonate, sodium carbonate is added to the sediment and heated. For that purpose the centrifuge tubes are placed in a water bath with boiling water for ten to twenty minutes, and the sediment is stirred up with a thin, glass rod. In that way, all the calcium oxalate is converted into calcium carbonate and the remaining oxalic acid into soluble sodiumoxalate.

$$(CaC_2O_4 + Na_2CO_3 = CaCO_3 + Na_2C_2O_4).$$

The remaining precipitate of calcium carbonate is centrifuged and washed repeatedly until the supernatant fluid no longer reacts alkaline to litmus paper. The supernatant fluid must always be very carefully pipetted off with capillary pipettes. When the washing is finished and the supernatant fluid removed, the remaining sediment is dried at 100° C. for fifteen minutes.

The dried sediment of calcium carbonate is then dissolved in N/50 hydrochloric acid, stirred up, and the tubes placed in a water bath with boiling water for three to five minutes. The calcium carbonate is changed by the action of the hydrochloric acid into calcium chlorid and carbonic acid. ($CaCO_3 + 2\,HCl = Ca + CO_2 + H_2O$).

The excess of hydrochloric acid is titrated with N/100 sodium hydroxid solution using methyl orange or dimethylamidoazobenzol as indicator.

Calculation

Multiply the amount of N/50 hydrochloric acid by two and subtract the amount of N/100 sodium hydroxid used for titration, in order to obtain the amount of hydrochloric acid (in terms of N/100 acid) which was needed for changing the calcium carbonate into calcium chlorid. Each cubic centimeter of N/100 hydrochloric acid corresponds to 0.2 milligrams of calcium.

Technique of Calcium Determination

The quantitative determination of calcium can be made, according to the investigation of F. Lebermann, with very small quantities of serum, for instance, in 0.1 c.c. However, it is advisable to use 1 c.c. of blood serum for the determination. The following is the procedure for using 1 c.c. of serum: exactly 1 c.c. of serum is placed in a centrifuge tube and 0.6 c.c. of ammonium oxalate is added to precipitate the calcium oxalate.

After standing for one-half hour the fluid is centrifuged for twenty to thirty minutes. Then the supernatant fluid is siphoned off and replaced by 1 c.c. of distilled water, the sediment stirred up and again centrifuged. That same washing process is repeated two or three times. The tubes with the washed sediment of ammonium oxalate are then placed in a sand bath and kept in the hot air apparatus at 200-250° C. for one-half to three-quarters of an hour. After that time add ten drops of sodium carbonate, place the centrifuge tube for ten to twenty minutes in a water bath with boiling water, and stir up the sediment.

The precipitate of calcium carbonate obtained by that procedure is centrifuged and repeatedly washed with water; each time 0.5 c.c. of distilled water are used. The washing is repeated until the supernatant fluid does not react alkaline to litmus paper. Then the supernatant fluid is very carefully drawn off and the sediment dried at 100° C. for fifteen minutes.

To the dried sediment 0.5 c.c. of N/50 hydrochloric acid are added, the substance is stirred up, and the centrifuge tube is placed in a water bath with boiling water for three minutes. Finally, one to two drops of indicator are added and then titrated from a microburette or micropipette with N/100 sodium hydroxid solution.

Example:

1 c.c. of serum was used for the determination, and 0.5 c.c. of N/50 hydrochloric acid in excess to bring the calcium carbonate in solution. We assume that 0.3 c.c. of N/100 sodium hydroxid solution were necessary to neu-

tralize the over-amount of acid. The calculation would, therefore, be: 0.5 c.c. of N/50 hydrochloric acid multiplied by two, gives 1 c.c. of acid (in terms of N/100 acid). If we subtract from that 1 c.c., 0.3 c.c. (the amount of N/100 sodium hydroxid for neutralization) we obtain 0.7 c.c. of N/100 acid, necessary to bring the calcium carbonate in solution. Therefore the amount of calcium in 1 c.c. of serum $0.2 \times 0.7 = 0.14$ mgs. calcium or, in 100 c.c. of serum, 14 mg. calcium.

Conclusion

The determination of the blood calcium according to the foregoing described method is somewhat elaborate and technically not very simple. However, it possesses the definite advantage, as this, the Lebermann's research work has proven, of yielding more nearly exact results than one may obtain by the method of permanganate titration, considering particularly the use of very small quantities of blood serum.

Literature. Ferdinand Lebermann: Eine neue klinische Methode zur Microkalziumbestimmung im Blutserum. Muenchen. med. Wchnschr. No. 40, 1924.

The Numerous Communities of Nursing Sisters and their Single Purpose

POOR FRANCISCANS OF PERPETUAL ADORATION

The Community in Europe

A small party of Sisters of St. Francis, driven out of their home in Westphalia, through the atrocious May laws of Prussia, arrived in New York, September 5, 1875, under the leadership of the late Mother Superior Mary Xaveria Termehr. Three days later they reached Iowa City, Iowa, where with the permission of the Rt. Rev. Bishop J. J. Hennessy of Dubuque, they decided to settle temporarily. A short sketch of this small community may here find a place.

It was in the year 1856, when Miss Josephine Termehr entered the convent of the school Sisters of the Holy Cross at Strassburg, Alsace. Upon taking the veil she was named Mary Xaveria, and laid the foundation for the work of teaching. The third of February, 1860, she, with several Sisters, went to Herford, Westphalia, to teach in the orphans' home and parochial school. As the distance from the motherhouse in Strassburg was disagreeable and annoying in many ways, permission was obtained from the mother superior of the order, Madam A. de Glaubitz, the Rt. Rev. Bishop Conrad Martin of Paderborn, Westphalia, and the Rt. Rev. Bishop Roesz, of Strassburg, Alsace, to elevate this settlement to a motherhouse, and Sister Xaveria was named mother superior. This occurred in the fall of 1861.

The rules of the Third Order of St. Francis, as laid down by the Holy Father Leo X for the monastic life, were adopted, and the community was placed under the direct management and control of the bishop of the diocese of Paderborn. The radical change in the Prussian church politics found in him a strong opponent, and he was seized and imprisoned at Fort Wesel. Death overtook him in banishment, but later the body of this noble martyr to his convictions was buried in his cathedral at Paderborn.

In the year 1866, when the unnatural civil war between Austria and Prussia broke out, the self-sacrificing love of their fellow beings showed itself among the Sisters, and they hastened to the front to care for and nurse the sick and wounded soldiers.

The bloody Franco-Prussian war once again found the Sisters on the field of battle. Their work of mercy on the fields of Pont-a-Mousson, Saarbrücken, and others, and in hospital and camp, has become a part of the history of that great war. Two of the Sisters succumbed to the terrible strain and died, one the 30th of August, the other September 3, 1870. They were buried at an elevated point in the soldiers' cemetery. After peace was declared, the Sisters returned to the convent. The health of several of them was seriously undermined and they soon followed their fellow Sisters to the grave.

In January, 1872, Mother Mary Xaveria, by order of Emperor William I of Germany, received from the hands of Empress Augusta the cross of merit. But alas, too soon destiny turned against them. The May laws of 1873 compelled the religious communities, including this, to leave the country.

The day of departure was fixed for August 20, 1875. At three o'clock A. M. the last holy mass was celebrated in the Sisters' beloved house-chapel. About half past four, as if under protest from the elements, they left the city of Herford in the midst of a downpour of rain, accompanied by loud peals of thunder. Without any further interruption they arrived at Rotterdam, where they took the steamer for America. The sea voyage was uneventful, a slight storm, followed by calm weather, enabling the seasick to recover and finish the trip in comfort. Thus they soon arrived at the land of refuge, the land which offers the oppressed an asylum, and gives to all men, social, political, and religious liberty.

The Community in America

As before mentioned, the Sisters arrived in New York, September 5, 1875. In the fall of the same year, Mother Xaveria visited the Rt. Rev. Bishop Hennessy in Dubuque, Iowa, and tendered him the following letter of introduction from the Rt. Rev. Bishop Conrad Martin:

Right Reverend and Honored Bishop and Brother:

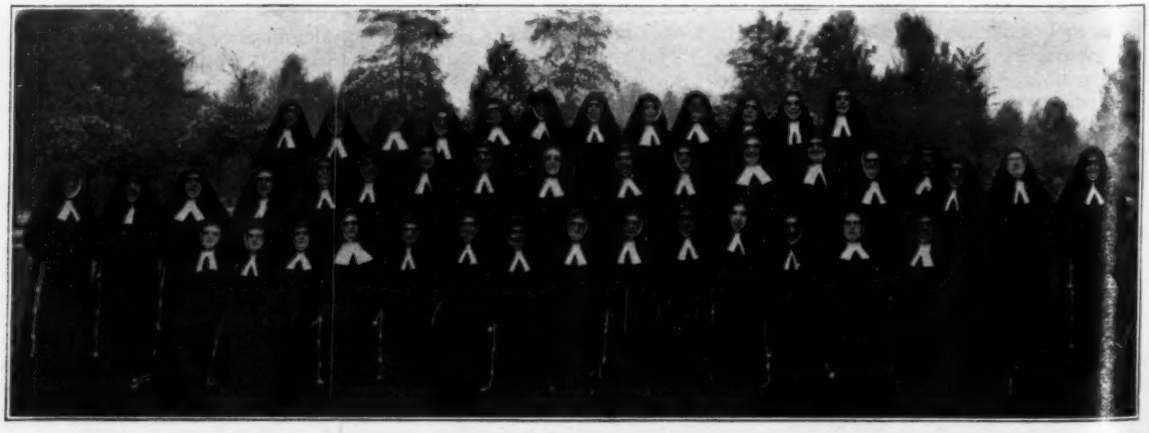
The Sisters of St. Francis have been engaged in my diocese in educating children and orphans as well as caring for the sick in a most praiseworthy manner, but on account of the cruel laws of the state of Prussia, they have been obliged to emigrate to America. These, my good daughters, I recommend in the warmest manner to your brotherly care.

With the highest respect and love, I remain

✠ CONRAD MARTIN, Bishop of Paderborn.
Now a prisoner in Fort Wesel.

Wesel, July 10th, 1875.

(Concluded on Page 30a)



SISTERS OF ST. FRANCIS OF PERPETUAL ADORATION (CREIGHTON MEMORIAL ST. JOSEPH'S HOSPITAL, OMAHA, NEBR.—450 BEDS).

Serve JELL-O with fruit as Jell-O Macedoine

26 oz. package makes a gallon

America's most famous dessert

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(Concluded from Page 276)

Mother Xaveria and the Sisters stayed at Iowa City until September 17, 1878. At this time they went to Dubuque, Iowa, upon invitation of Rt. Rev. Bishop Hennessy to found an orphans' home and to take charge of the schools. Alas.. the humane and self-sacrificing work of Mother Xaveria was brought to a close by her death the 12th of April, 1892. She was deeply and sincerely mourned by all who knew her. The community follows her example and their work has been blessed with success. As Sisters of the order and children of the great St. Francis, they are still united in love and good will, and although their field of labor is different and divided, they have one object in view: charity and neighborly love.

In the spring of 1876, Mother Xaveria received an inquiry in regard to founding a hospital in Peoria, Illinois. As a result, the Sisters started, with the usual difficulties of organization, the St. Francis Hospital of Peoria, with subsequent changes and additions to meet the increasing demands for its services. Here also was instituted the motherhouse of the community.

Since that time the Sisters have greatly enlarged upon their efforts through the establishment of other hospitals, including St. Joseph's at Bloomington, Ill.; St. Francis at Burlington, Iowa; St. Francis at Escanaba, Mich.; St. Joseph's at Keokuk, Iowa; St. Anthony's in Rockford, Ill.; St. Joseph's at Menominee, Mich.; St. Mary's at Marquette, Mich.; St. James' at Pontiac, Ill.; St. Mary's at Galesburg, Ill.; and the Sacred Heart Hospital at Fort Madison, Iowa.

Add Therapeutic Department. An electric-hydro therapeutic department has been installed at St. Thomas' Hospital, Marshalltown, Ia. The department includes both electric and vapor baths, and will be available for patients who desire such treatment at the hands of experienced operators. The department is located on the ground floor, and has a restroom in connection.

Louisiana Forms New Organization. The Louisiana Nurses' Board of Examiners called a meeting of the hospital superintendents and directors of schools of nursing at the Touro Infirmary, New Orleans, La., on February 25th, with a view to forming an organization whose object would be the exchange of ideas on hospital and nursing problems and closer cooperation. Representatives from all accrediated hospitals and schools of nursing in the state were in attendance and a stimulating meeting was held. The new organization formed is known as the Louisiana Association of Directors of Schools of Nursing.

The officers elected are, president, Dr. John D. Spelman, superintendent, Touro Infirmary, New Orleans, La.; vice-president, Nena T. Self, R. N., director, School of Nursing, North Louisiana Sanatorium, Shreveport, La.; secretary-treasurer, Sister Kostka, R. N., director, School of Nursing, Charity Hospital, New Orleans, La.

SODALITY PROGRESS

As every profession having its affiliated sodality, or society, the Catholic nurses of St. Margaret Hospital, Hammond, Indiana, have the sodality of the B. V. M. established in their institution. Nurses in general feel that religion plays an important part in one's life and especially in the career of caring for the sick. The nurse deals with human life directly, but often the occasion of spiritual care presents itself, and how can a nurse be better equipped to handle such circumstances, than by fostering devotion, knowledge, and spiritual adaptability through a religious organization?

This sodality was organized on December 8th, 1923, with twenty charter members, and with the Little Flower of Jesus as the patron saint. Even though it is but a year old, the sodality, through the cooperation of its members, has done much toward the forming of character and religious ideals.

On the third Sunday of each month, which was selected as regular holy communion Sunday, the sodality forms the choir at holy mass. The little office of the B. V. M. is recited in the chapel on the Friday evening following. At the regular meetings, following the office, and held in the lecture hall, papers by members of the sodality, dealing with character and the nursing profession in general, form the usual program, and the reverend chaplain offers a monthly spiritual chat.

The officers of the sodality are chosen by ballot at the meeting held the first month of each year. The officers for the year 1924, because they were the first elected, were obliged to lay the corner-stone of the sodality, but with the cooperation of the sodalists much was accomplished.

The officers for 1925 were elected in January. As yet their work lies before them, but they have already shown that they are enthused over their plans, and through their efforts the sodality has entered into divers activities.

A standing committee regulates and cares for the wants of the nurses' library. The sodality through a committee has established a spiritual section for mission work, and there is also a section looking after the social activities of the nurses.

A beautiful banner bearing the painting of the Immaculate Conception as "Queen of Heaven," has been purchased and adorns the chapel on the sodality Sunday. The sodality was the recipient of a beautiful statue of the Little Flower of Jesus, presented by the spiritual director.

The venerable Sister superintendent of the nurses is an ex-officio member of every committee, acting in her capacity of prefect, and to her zeal and prudent suggestions the sodality owes much of its success.

GUILD MEMBERS

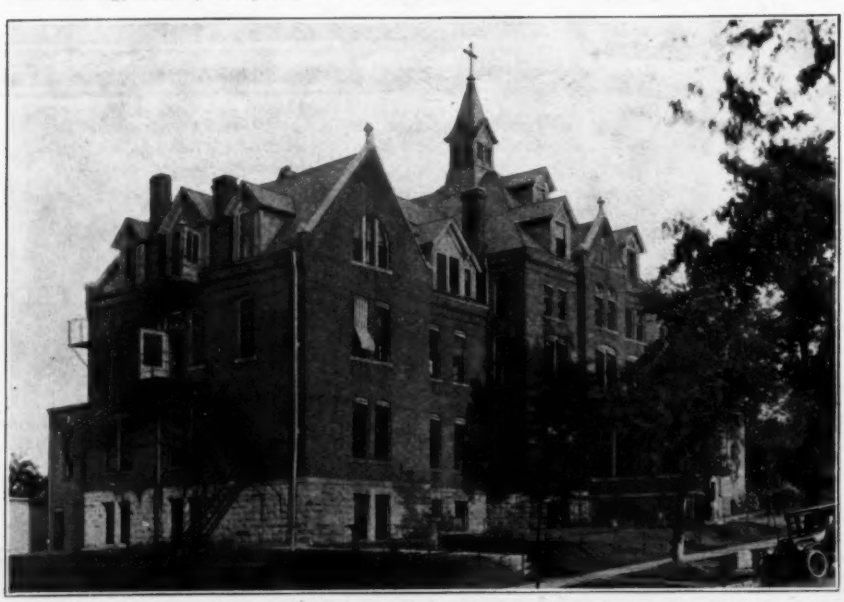
April report of cities and states which have a representation of more than ten members in the International Catholic Guild of Nurses:

States

Wisconsin	55
Illinois	52
New York	47
Pennsylvania	47
Missouri	45
New Jersey	36
Ohio	36
Maryland	20
Kentucky	19
Iowa	16
Michigan	15
Minnesota	15
Texas	15
South Dakota	13
Kansas	12
California	11
District of Columbia	11

Cities

Kansas City, Missouri	27
Trenton, New Jersey	23
Janesville, Wisconsin	22
New York City, New York	22
Toledo, Ohio	21
Pittsburgh, Pennsylvania	19
Baltimore, Maryland	18
Chicago, Illinois	18
Louisville, Kentucky	17
Houston, Texas	12
Milwaukee, Wisconsin	12
Washington, D. C.	11



ST. FRANCIS HOSPITAL, BURLINGTON, IOWA, CONDUCTED BY THE SISTERS OF THE THIRD ORDER OF ST. FRANCIS (50 BEDS).